



**BEHAVIOR  
ATTENTION &  
DEVELOPMENTAL  
DISABILITIES**

5779 Getwell Road, Building D, Suite 3  
Southaven, MS 38672

**662-510-6507 (Phone) 844-445-7727 (Fax)**

## **Policies and Procedures Agreement**

*Please indicate that you have read each section by initialing as designated OR by choosing statements most appropriate for you when specified.*

### **Office Hours and Appointments**

Providers are in the office at different times during these days (the receptionist will be able to help you with scheduling on the days your provider(s) is in the office). All appointments are scheduled. Appointment lengths vary from 60 to 90 minutes for initial intake (depending on provider) and 30 to 60 minutes for treatment session (depending on the need of the client). ABA sessions vary in length based on the client's need.

\*\*If the patient is at least 15 minutes late arriving for the appointment, the visit will be cancelled at the discretion of the provider as this will impact other patients' appointments.

**Initial here:** \_\_\_\_\_

### **Parent Attendance**

Clinic policy is that the parents or guardian of a client must stay at the clinic for the duration of treatment unless otherwise agreed with provider.

**Initial here:** \_\_\_\_\_

### **Telephone Service**

The phones are answered as staff is available. If you leave a message, every effort will be made to have one of the office staff return your call the same day (unless it is received after 4:30 p.m. M-Th or after 12:30 p.m. on Friday). Messages left on Friday will be returned by office staff on the following Monday. As a rule, providers are scheduled to see clients the majority of their day and do not take phone calls when they are with a client. Providers return phone calls when they have available time during regular business hours.

**Initial here:** \_\_\_\_\_

**Emergency Access**

Since Behavior, Attention, and Developmental Disabilities Consultants, LLC is an outpatient clinic, if the office staff cannot access a provider immediately or it is a Saturday, Sunday, or holiday, and you have an emergency, **please call 911 or go to your nearest emergency room.** Please call the office at your earliest convenience after that action to inform the provider of the situation. Below are other resources that can help during emergencies.

24 hour / 7 day Emergency Mental Health Resources

24 hour Crisis Line	1-800-681-7444
Adult Mobile Crisis	1-855-274-7471
Youth Mobile Crisis	1-866-791-9226

**Initial here:** \_\_\_\_\_

**Subpoenas / Court Appearances**

In the event disclosure of your records or the provider’s testimony are requested by you or required by law, you will be responsible for and shall pay the costs involved in producing the records, preparing for and giving testimony. Court appearance fees are charge by the hour, rounded to the nearest 15-minute interval. Time starts once your provider steps into the court house, law office, or meets with your legal representative at Behavior, Attention, and Developmental Disabilities Consultants, LLC.

**Initial here:** \_\_\_\_\_

**Appointment Reminders**

Behavior, Attention, and Developmental Disabilities Consultants, LLC will send appointment reminders via text message or email. These reminders may be the only notification you will receive, and that it is ultimately your responsibility to arrive on your appointed day and time. If you are unable to attend, you must contact the office at least 24 hours in advance (see Attendance policy). Please notify Behavior, Attention, and Developmental Disabilities Consultants, LLC promptly should your phone number/email address change.

**Please select the statement below that is appropriate for you:**

**O Send reminders to this email address:** \_\_\_\_\_

**O Send text message reminders to this cell phone:** \_\_\_\_\_  
Area Code + number

**O Do not send text/email reminders. I prefer to be called at this number:** \_\_\_\_\_  
Area Code + number

**Attendance, Missed Appointments and Cancellations**

Scheduled appointments are set especially for the specific patient, and consistent attendance is an integral part of the therapeutic process. Missed appointments and frequent cancellations may impact the treatment process. Appointments are also in very high demand. If either of the below situations occur, a client’s standing appointment will be forfeited. He/she will be placed on our waiting list and will be seen based on the provider’s availability:

- **Miss two appointments in a row, without a 24 hour notice**
- **Miss two appointments within one month, without a 24 hour notice**
- **Miss more than four sessions within two months, regardless of 24 hour notice**

*If there are extenuating circumstances (e.g., medical reasons, out of the country travel, etc.) special consideration may be given at the discretion of the practice manager and therapist.*

**Initial here:** \_\_\_\_\_

**Copies of Medical Record**

Upon receipt by the office staff of a request for medical records, an Behavior, Attention, and Developmental Disabilities Consultants, LLC Request for Medical Records form will be filled out and provided to appropriate provider(s). All records will be reviewed and signed off on by the provider(s) within 10 business days unless circumstances do not permit (e.g., illness, vacation, etc.).

The first copy of medical records will be complimentary for the patient (or parent/guardian). All subsequent copies will have a fee of \$1.00 per page for a maximum of \$25.00 (per copy). For additional copies, the fee must be paid before records are released. A valid signed consent form has to be on file before records are released to anyone other than the patient (or parent/guardian).

**Initial here:** \_\_\_\_\_

**Medical Records**

Under HIPPA regulations, patient records are to be accessible to the individual client (and/or parent/guardian) upon request. This access can be in the form of copies of any and all documentation in the chart (with the exception of testing protocols which may be reviewed but not copied) or visually viewing the chart and its' contents in a controlled environment with office staff present. A request to visually review records will have to be given in writing to the Office Manager. Following receipt of that request, an appointment will be scheduled within 5 business days at a time that is mutually agreeable and convenient for the patient and provider. Your medical record will be maintained for 10 years from the point you stop receiving services. After this point, your record may be destroyed.

**Initial here:** \_\_\_\_\_

**Video/Audio Recording Policy**

Video/audio recording, and taking photos of sessions and patients by anyone is strictly prohibited without the written consent of the therapist. Under no circumstances should ANY audio/video recordings be posted to social media.

**Initial here:** \_\_\_\_\_

**Use of Voicemail, Email and Text**

Staff at Behavior, Attention, and Developmental Disabilities Consultants, LLC may leave voice messages as a courtesy when confirming appointments, if an appointment needs to be rescheduled, for billing and insurance purposes, and to relay a message from a provider.

**Please initial the statement below that is appropriate for you:**

- \_\_\_\_\_ Yes, voicemail can be used as a way to communicate the above information.
- \_\_\_\_\_ No, voicemail cannot be used as a way to communicate the above information.

Some individuals prefer to receive email communication regarding client needs (e.g., scheduling appointments, contacting clinic providers, relaying messages to a provider). Even though all emails sent through Behavior, Attention, and Developmental Disabilities Consultants, LLC are sent with a confidentiality message, email is not considered a secure communications medium. If you choose to use email as a medium for communication, Behavior, Attention, and Developmental Disabilities Consultants, LLC and undersigned provider do not guarantee privacy will be maintained through the chain of custody between us.

**Please initial the statement below that is appropriate for you:**

\_\_\_\_\_ Yes, email can be used as a way to communicate the above information.

\_\_\_\_\_ No, email cannot be used as a way to communicate the above information.

**Please provide appropriate Email:** \_\_\_\_\_

Text messaging will not be used by Behavior, Attention, and Developmental Disabilities Consultants, LLC providers as a communication method, except for appointment reminders.

**Initial here:** \_\_\_\_\_

### **Relationship**

Your relationship with the provider is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the provider not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the provider.

**Initial here:** \_\_\_\_\_

### **Limits to Confidentiality**

Discussions between a provider and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse as defined by Mississippi law; abuse of the elderly or disabled; HIV infection and possible transmission; criminal prosecutions, child custody cases; suits in which mental health of a party is an issue; situations where the provider has a duty to disclose, or where in the provider's judgment, it is necessary to warn, notify, or disclose; fee disputes between the provider and the client; a negligence suit brought by the client against the provider; or the filing of a complaint with a licensing board or other state or federal regulatory authority.

If you have any questions regarding confidentiality, you should bring them to the attention of the provider when you and the provider discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned provider to share confidential information with all persons mandated by law, with the agency that referred you, and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services.

You are also releasing and holding harmless the undersigned provider from any departure from your right of confidentiality that may result.

**Initial here:** \_\_\_\_\_

### **Duty to Warn**

In the event that the undersigned provider reasonably believes that a client is a danger, physically or emotionally, to him/herself or another person, the provider has a professional duty to warn the person in danger and to contact any person in position to prevent harm to the client or another person, in addition to medical and law enforcement personnel.

**Initial here:** \_\_\_\_\_

## **CLIENT RIGHTS, ACCESS TO CARE, INVOLVEMENT IN CARE**

**Policy:** Supports the rights of each client and is committed to ensuring the protection of those rights in its access to care, provision of care, treatment and services.

**Procedures:**

1. Behavior, Attention, and Developmental Disabilities Consultants, LLC will post Client Rights information where clients can see them. Will make available written copies of Client Rights in language clients can understand. Clients will be informed of their rights upon request.
2. Any person has a Right to Treatment in accordance with the following:
  - Access to care, as long as that care is within Behavior, Attention, and Developmental Disabilities Consultants, LLC's capacity, mission, and policies.
  - Knowledge of Behavior, Attention, and Developmental Disabilities Consultants, LLC's relationships with outside parties that may influence your treatment and care. These may be with educational institutions, other healthcare providers, or insurers.
  - Be informed if Behavior, Attention, and Developmental Disabilities Consultants, LLC cannot provide the care needed, and of other choices of care.
3. Any person receiving services has the following rights:
  - The right to be treated in a humane and dignified manner at all times with respect to personal dignity, personal privacy, civil rights and civil liberties.
  - Freedom from all forms of coercion, abuse or harm.
  - The greatest degree of freedom possible, limited only by dangerousness to self or others, or (if inpatient), potential elopement risk or Court ordered commitments.
  - Freedom from involuntary seclusion or restraints of any form unless medically there is imminent physical danger to client or others, and a physician orders the seclusion or restraints.
  - The right to participate in the treatment/service process, be present in meetings or discussions affecting treatment/service, play an active role in decision-making process, disagree with the conclusions of treatment team (if applicable), and to participate in discharge planning.
  - The right to receive services that are sensitive to client beliefs, values, and culture.
  - Confidentiality rights.
  - Personhood, or right to maintain self-identity.
  - The right to self-advocate to the best of his/her ability
  - Due process, which includes Grievance Rights and rights to file a lawsuit.

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**I understand the disclosure above.**

## Intake Form

### Patient Information

Person completing the Intake Form: \_\_\_\_\_ Relation to Parent: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Nickname/Goes by: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

School (if applicable): \_\_\_\_\_ Current Grade (if applicable): \_\_\_\_\_

### Emergency Contact Information:

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

### Responsible Party (Financial) Information

Guarantor's Name: \_\_\_\_\_ Guarantor's Date of Birth: \_\_\_\_\_

Guarantor's Social Security Number: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address (if different than patient): \_\_\_\_\_

Guarantor's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

### Insurance Information (Provide copies of your insurance card(s) to Reception Desk):

Primary Insurance Name: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

# Financial Policy Agreement

## Acceptance and Submission to Insurance Companies

**Insurance deductibles, co-insurance, co-payments, and all balances remaining after your insurance has paid on previous claims are due at the time service is rendered. All insurance benefits will be assigned to Behavior, Attention, and Developmental Disabilities Consultants, LLC unless the Responsible Party pays the entire amount of services at each visit.**

**Initial Here:** \_\_\_\_\_

As a service and courtesy to patient, staff at Behavior, Attention, and Developmental Disabilities Consultants, LLC will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and are not responsible for the collection of such payments. In some cases, insurance companies may not consider certain services medically necessary or may determine that certain services are not covered by your policy (or require preauthorization before the services can be offered). In such cases, the Responsible Party listed below is responsible for payment of these services.

**Initial Here:** \_\_\_\_\_

I authorize Behavior, Attention, and Developmental Disabilities Consultants, LLC to disclose case records (including but not limited to diagnosis, progress notes, psychological reports, testing results, and/or other requested information) to my third party payer or insurance company for the purpose of claims processing and receiving payment directly to Behavior, Attention, and Developmental Disabilities Consultants, LLC and its providers. I consent that Behavior, Attention, and Developmental Disabilities Consultants, LLC and its providers may discuss with or release billing/insurance information with my insurance company or third party provider. I understand that access to this information will be limited to determining insurance benefits and will be accessible to persons who employment is to determine payments and/or insurance benefits.

**Initial Here:** \_\_\_\_\_

I understand that there will be a \$25.00 returned check fee for any check written for services and returned by my financial institution. This fee is in addition to any fees charged by my financial institution and will be paid in cash to Behavior, Attention, and Developmental Disabilities Consultants, LLC and/or its provider.

**Initial Here:** \_\_\_\_\_

\_\_\_\_\_  
**Responsible Party Name (printed)**

\_\_\_\_\_  
**Responsible Party Date of Birth**

\_\_\_\_\_  
**Responsible Party Signature**

\_\_\_\_\_  
**Date**

## Consent for Treatment

I authorize and request my provider to carry out diagnostic evaluations and treatment which now or during the course of my (or my child's) treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand while the course of my treatment is designed to be helpful, my provider can make no guarantees about the outcome of my treatment.

While assessment and therapy may provide significant benefits, it may also pose risks. For children and adults, the therapy process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. For children with developmental, communication, and behavioral difficulties, some behavioral interventions may lead to an initial increase in undesired behaviors. The providers who work with children with a high level of undesired behavior have been trained in handling undesired behavior through use of crisis intervention techniques. In all cases, these reactions will be worked on between my provider and me.

**Initial here:** \_\_\_\_\_

If I have any questions regarding this consent form and/or about the services offered at Behavior, Attention, and Developmental Disabilities Consultants, LLC I will discuss them with the appropriate provider(s). I have read and understand the above information. I consent to participate in evaluation and treatment offered by Behavior, Attention, and Developmental Disabilities Consultants, LLC. Furthermore, I understand that I may stop treatment at any time.

\_\_\_\_\_  
**Patient Name (printed)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Signature or Legal Guardian if patient under 18**

\_\_\_\_\_  
**Date**

If I am seeking treatment at Behavior, Attention, and Developmental Disabilities Consultants, LLC for a minor child, I attest that I am at least 18 years of age and the parent, legal guardian, or temporary medical guardian of that child. If I am a parent with full custody, legal guardian, or temporary medical guardian of the minor child, I will provide appropriate documentation at the initial appointment for the aforementioned minor child. As above, I have read and understand the above information. I consent to for the minor child to participate in evaluation and treatment offered by Behavior, Attention, and Developmental Disabilities Consultants, LLC. Furthermore, I understand that I may stop treatment for the minor child at any time.

\_\_\_\_\_  
**Patient Name (printed)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent or Legal Guardian Signature**

\_\_\_\_\_  
**Date**



## Acknowledgement of Forms and Information

I acknowledge I reviewed and was offered

- 1) A copy of the Notice of Privacy Practices,
- 2) The office Policies and Procedures (including consent to treatment) and
- 3) The financial agreement for Behavior, Attention, and Developmental Disabilities Consultants, LLC

I also had the opportunity to ask questions about any of the above documents and had them sufficiently answered.

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Printed Name of Client

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Signature of Party Financially Responsible/Parent/Guardian      Date

# ABA BASED SERVICES - FAMILY INVOLVEMENT

**Policy:** Supports the rights of each client through outlining family involvement and family responsibilities.

## **Procedures:**

- Behavior, Attention, and Developmental Disabilities Consultants, LLC will make available written copies of Family Involvement Policy in language clients can understand. Families will be informed of their rights upon request.
- Any family of a minor child or a person who requires guardianship (i.e., person over the age of 18 whose family members have guardianship due to the impact of the disability) needs to be aware of the following:
  - Parent/Guardian Meetings and Conferences: staff are eager to meet with you whenever it is possible. You will have frequent contact and conversations with the providers at each session. However, if you have specific topics to discuss, please arrange a meeting through the Receptionist to meet with the provider (and/or supervisor) at a scheduled session time.
  - You will have ongoing contact with your consultant through sessions and parent training sessions.
  - Phone and email (if signed on the consent paperwork) communication can also be used.
  - Parents/guardians are expected to be present/available at treatment sessions to acquire skills, facilitate communication, and in case of an emergency.
- Your child should be dressed and fed prior to arrival at the clinic for sessions, unless these skills are specifically being addressed in their program. This does not include small snacks such as Goldfish, chips, etc.
- Please arrive on time to drop off and pick up your child. ABA sessions strictly start at either 8:15 AM or 12:45 PM and end at either 12:15 PM or 4:45 PM, respectively.
  - If the patient is 15 minutes or more late arriving for the appointment, the visit will be cancelled at the discretion of the provider as this will impact other patients' appointments.
  - If your child is late to session, the ending time of the session is not adjusted to accommodate for the lost time.
  - Parents/guardians are responsible for informing Behavior, Attention, and Developmental Disabilities Consultants, LLC if a child cannot attend a session due to illness or other scheduling conflicts.
- Missed appointments and frequent cancellations impact the treatment process. Appointments are also in very high demand. If any of the below situations occur, a client's standing appointment will be forfeited. He/she will be placed on our waiting list and will be reenrolled in services based on the provider's availability:
  - Miss two appointments in a row, without a 24 hour notice
  - Miss two appointments within one month, without a 24 hour notice
  - Miss more than four sessions within two months, regardless of 24 hour notice
  - *If there are extenuating circumstances (e.g., medical reasons, out of the country travel, etc.) special consideration may be given at the discretion of the practice manager and therapist.*
- Behavior, Attention, and Developmental Disabilities Consultants, LLC makes every effort to prevent the spread of communicable disease among staff and children. The purpose of our policy on illness is to protect and maintain a safe and healthy clinic environment for all individuals.
  - If any health related issues arise, a supervisor and the office manager will evaluate, and the parent(s) or guardian(s) or the sick individual may be called upon to bring their son/daughter home in order to prevent further spread of infection.
  - Behavior, Attention, and Developmental Disabilities Consultants, LLC's policy is to ask you to cancel your session when your child shows any of the following symptoms:
    - A fever of 100 degrees or higher
      - If your child has a fever of 100 degrees or above, he/she must be fever free for at least 24 hours WITHOUT fever reducing medication (i.e. Tylenol) in order to return to therapy
    - Diarrhea
    - Vomiting or upset stomach
    - Eyes that are red or have discharge
    - Severe coughing, runny nose with heavy greenish discharge
    - Contagious illnesses such as chicken pox, Strep throat, Foot/mouth disease, etc.
  - When your child has a fever, diarrhea, or any other kind of illness, he/she cannot return to therapy until symptoms are absent for 24 hours or he/she has a physician's note clearing them for return.
- Not being satisfied with your child's services is a challenging situation. Please discuss concerns with your provider's supervisor. If there is not resolution, please refer to Behavior, Attention, and Developmental Disabilities Consultants, LLC's Grievance Policy.



5779 Getwell Road, Building D, Suite 3  
Southaven, MS 38672

662-510-6507 (Phone) 844-445-7727 (Fax)

## Notice of HIPAA Privacy Rules

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Behavior, Attention, and Developmental Disabilities Consultants, LLC and its providers must by law keep your health information private and give you notice of its legal duties and privacy practices for your health information.

### **I. How Behavior, Attention, and Developmental Disabilities Consultants, LLC May Use or Disclose your Health Information**

In certain situations, which will be described in Section II below, we must obtain your written authorization in order to use and/or disclose your protected health information (PHI). However, we do not need any type of authorization from you for the following uses and disclosures of your PHI (including, if any, your HIV/AIDS related, genetic information, sexually transmitted disease or tuberculosis information):

- 1. Treatment.** We use and disclose PHI to physicians, nurses and other health care personnel who provide you with health care services or are involved in your care. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.
- 2. Payment.** We may use and disclose PHI to obtain payment for services that we provide to you. For example, disclosures to claim and obtain payment from your health insurer, HMO or other company that arranges or pays the cost of some or all of your healthcare to verify that your payer will pay for health care. You should be aware if you are not the policy holder, certain information may be disclosed to the policy holder by the insurance carrier.
- 3. Healthcare operations.** We may use and disclose PHI for our healthcare operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, licensed psychologists, licensed professional counselors, and other provider types. We may disclose PHI to our administrative staff to conduct medical reviews, needs assessment, and to check quality control of services available. We may also provide PHI to your other healthcare providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of healthcare professionals, or healthcare fraud and abuse detection or compliance.
- 4. Information provided to you.** Behavior, Attention, and Developmental Disabilities Consultants, LLC allows you to look at your medical records. You must make the request in writing. If we do not have your PHI but we know who does, we will tell you how to get it.
- 5. Notification and communication with family.** We may disclose PHI to a family member, your personal representative or any other person identified by you responsible for your care about where you are, your general condition, or if you die. If you are able and can agree or object, Behavior, Attention, and Developmental Disabilities Consultants, LLC will give you a chance to object prior to making this notification. If you are unable or cannot agree or object, our health professionals will use their best judgment in telling your family and others.
- 6. Required by law.** As required by law, we may use and disclose you PHI.
- 7. Public health.** We may disclose your PHI to public health authorities for purposes related to: preventing or controlling disease, report child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
- 8. Health oversight activities.** We may disclose your PHI to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
- 9. Judicial and administrative proceedings.** We may disclose your PHI in the course of any administrative or

judicial proceeding.

**10. Specialized government functions.** We may disclose your PHI for the military, national security, correctional institutions and government benefits purposes.

**11. Law enforcement.** We may disclose your PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

**12. Deceased person.** We may disclose your PHI to coroners, medical examiners and funeral directors.

**13. Research.** We may disclose your PHI to those doing research that we have approved.

**14. Public Safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

**15. Worker's compensation.** We may disclose PHI to comply with worker's compensation laws.

**16. Provider's Incapacity or Death.** We would disclose PHI to a designated provider in the event of incapacitation or death of your provider. The other licensed professional will then be able to supply patients with copies upon receiving and an appropriate signed medical records release, or transfer records to a provider chosen by the patient or guardian.

## **II. When Behavior, Attention, and Developmental Disabilities Consultants, LLC May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices; Behavior, Attention, and Developmental Disabilities Consultants, LLC will not use or disclose your health information without your written authorization. If you do authorize Behavior, Attention, and Developmental Disabilities Consultants, LLC to use or disclose your PHI for another purpose, you may take back your authorization in writing at any time.

## **III. Your Health Information Rights**

**1. *You have the right to ask for restrictions on certain uses and disclosures of your PHI.*** Behavior, Attention, and Developmental Disabilities Consultants, LLC does not have to agree to the restriction that you request.

**2. *You have the right to get your PHI through a reasonable alternative means or at an alternative location.*** You must present a written Behavior, Attention, and Developmental Disabilities Consultants, LLC form which tells your specific request. There will be a charge to get this information. (\$1.00 per page for a maximum of \$25.00-Per Request). A valid signed consent form has to be on file before records are released to anyone other than the patient (or parent/guardian).

**3. *You have the right to see and obtain a copy of your PHI.*** Under limited circumstances, we may deny you access to a portion of your records. (You should take note that, if you are a parent or legal guardian of a minor, certain portions of the minor's medical record will not be accessible to you including records relating to pregnancy, abortion, sexually transmitted disease, substance use and abuse, and contraception and/or family planning services.) You must submit a completed Behavior, Attention, and Developmental Disabilities Consultants, LLC Release of Information form. If you request copies, \$1.00 per page for a maximum of \$25.00-Per Request.

**4. *You have the right to request that Behavior, Attention, and Developmental Disabilities Consultants, LLC change your PHI that is not correct or complete.*** Behavior, Attention, and Developmental Disabilities Consultants, LLC does not have to change your PHI if we feel that the information is correct or other special circumstances apply.

**5. *You have a right to get a list of disclosures of your PHI made by Behavior, Attention, and Developmental Disabilities Consultants, LLC,*** except for disclosures for: treatment, payments, healthcare operations, information provided to you, certain government functions of Section I of this Notice of Privacy Practices during any period of time prior to the date of your request, provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003.

## **IV. Changes to this Notice of Privacy Practices**

Behavior, Attention, and Developmental Disabilities Consultants, LLC reserves the right to change this Notice at any time in the future, and to make the new provisions effective for all information that it keeps, including information that was created or received prior to the date of such change. Until such change is made, Behavior, Attention, and Developmental Disabilities Consultants, LLC must comply with this notice. If we change this Notice, we will post the new notice in waiting areas and have copies available upon your request.

If you have questions about any part of this notice or if you want more information about the privacy practices at Behavior, Attention, and Developmental Disabilities Consultants, LLC, please contact:

Kami Morgan, Office Manager  
5779 Getwell Road Bldg. D3  
Southaven, MS 38672, 662.510.6507



## **Notice of Organizational Policies**

### **NONDISCRIMINATION POLICY**

As a recipient of federal financial assistance, Behavior, Attention, and Developmental Disabilities Consultants, LLC does not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by Behavior, Attention, and Developmental Disabilities Consultants, LLC's employees directly or through a contractor or any other entity with whom the Behavior, Attention, and Developmental Disabilities Consultants, LLC arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, and 91.

In case of questions concerning this policy, or in the event of a desire to file a complaint alleging violations of the above, please contact:

Kami Morgan, Office Manager  
5779 Getwell Road Bldg. D3  
Southaven, MS 38672, 662.510.6507

### **PROCEDURE FOR COMMUNICATING INFORMATION TO PERSONS WITH SENSORY IMPAIRMENTS**

Behavior, Attention, and Developmental Disabilities Consultants, LLC will take such steps as are necessary to ensure that qualified persons with disabilities, including those with impaired sensory or speaking skills, receive effective notice concerning benefits or services or written material concerning waivers of rights or consent to treatment. All aids needed to provide this notice are provided without cost to the person being served.

For Persons With Hearing Impairments: Qualified sign-language interpreter for persons who are deaf/hearing impaired and who use sign-language as their primary means of communication, the following procedure has been developed and resources identified for obtaining the services of a qualified sign-language interpreter to communicate both verbal and written information:

1. Please contact Kami Morgan or the Clinic's Receptionist regarding the need for a qualified sign-language interpreter.
2. Our agency typically utilizes Deaf Connect of the Mid-South, Inc. for our servicing need and will need to coordinate via availability of both the patient and the outside service provider.

For Persons With Visual Impairments: Reader/staff will communicate the content of written materials concerning benefits, services, waivers of rights, and consent to treatment forms by reading them out loud to visually impaired persons.

For Persons With Speech Impairments: Writing materials, typewriters, and computers are available to facilitate communication concerning program services and benefits, waivers of rights, and consent to treatment forms.

## **PROCEDURE FOR COMMUNICATION WITH PERSONS OF LIMITED ENGLISH PROFICIENCY POLICY**

It is the policy of Behavior, Attention, and Developmental Disabilities Consultants, LLC to provide communication aids (at no cost to the person being served) to Limited English Proficient (LEP) persons, including current and prospective patients, clients, family members, interested persons, et al., to ensure them a meaningful opportunity to apply for, receive or participate in, or benefit from the services offered. The procedures outlined below will reasonably ensure that information about services, benefits, consent forms, waivers of rights, financial obligations, etc., is communicated to LEP persons in a language which they understand. Also, they will provide for an effective exchange of information between staff/employees and patients/clients and/or families while services are being provided.

### **PROCEDURE:**

1. Behavior, Attention, and Developmental Disabilities Consultants, LLC staff will be responsible for implementing methods of effective communication with LEP persons.
2. Behavior, Attention, and Developmental Disabilities Consultants, LLC will:
  - a. Maintain and routinely update a list of all bilingual persons, organizations, and staff members who are available to provide bilingual services, and
  - b. Develop written instructions on how to gain access to these services, i.e., contact persons, telephone numbers, addresses, languages available, hours available, fees and conditions under which the person(s) are available.
3. In order to ensure effective communication and to protect the confidentiality of patient information and privacy, the patient will be informed that the services of a qualified interpreter are available to him/her at no additional charge. Only after having been so informed, the patient may choose to rely on a family member or friend in a particular situation. The choice of the patient and presence of an interpreter will be documented after every visit.

### **SECTION 504 NOTICE OF PROGRAM ACCESSIBILITY**

This provider/vendor and all of its programs and activities are accessible to and usable by disabled persons, including persons with impaired hearing and vision. Access features include:

- Convenient off-street parking designated specifically for disabled persons.
- Curb cuts and ramps between parking areas and buildings.
- Level access into first floor level. There are no upper levels.
- Fully accessible offices, meeting rooms, bathrooms, public waiting areas, patient treatment areas, including therapy rooms.
- A full range of assistive and communication aids provided to persons with impaired hearing, vision, speech, or manual skills, without additional charge for such aids.

**If you require any of the aids listed above, please let the receptionist or your provider know.**