Learning Dreams LLC
5103 West Pierson Road, Suite 3
Flint MI 48504-1395
810-391-2923

1. Welcome!

Welcome to Learning Dreams LLC.

Thank you for filling in all of these forms as completely as possible. The more details we have on the client the better we can provide service.

Please take care to complete as many of the questions in as much detail as possible. This information you provide really does help us best address your concerns.

If you have any questions at all, please contact us immediately at (810) 391-2923. Thank you!

These forms must be returned to the office prior to your first appointment.

Learning Dreams LLC
5103 West Pierson Road, Suite 3
Flint MI 48504-1395

FAX: (810) 391-2968

2. Client's Primary Reason for Visiting

Tell Us What Brings You In

What is the primary reason for your visit today?

Has the client previously been evaluated for this, or other concerns? (i.e. occupational therapy, physical therapy, speech, ABA, or counseling services - at school or in a private setting)? If YES, please explain.

What, if any, SUCCESSFUL strategies have been tried with the client?

What, if any, UNSUCCESSFUL strategies have been tried with the client?

What do you feel are the client's biggest challenges/weaknesses?

Current Symptoms

Anxiety ☐ (yes, if checked)

Impulsivity ☐ (yes, if checked)

Appetite Issues ☐ (yes, if checked)

Irritability ☐ (yes, if checked)

Avoidance ☐ (yes, if checked)

Libido Changes ☐ (yes, if checked)

CryingSpells ☐ (yes, if checked)

Loss of Interest ☐ (yes, if checked)

Depression ☐ (yes, if checked)

Panic Attacks ☐ (yes, if checked)

ExcessiveEnergy ☐ (yes, if checked)

Racing Thoughts ☐ (yes, if checked)

Fatigue ☐ (yes, if checked)

RiskyActivity ☐ (yes, if checked)

Guilt ☐ (yes, if checked)

Sleep Changes ☐ (yes, if checked)

Hallucinations ☐ (yes, if checked)

Suspiciousness ☐ (yes, if checked)

If the answer to any of the following questions is NO please provide some examples.

Does the client use appropriate attention seeking behaviors (Yes/No)?

Does the client maintain appropriate eye contact (Yes/No)?

Does the client follow verbal directions (Yes/No)?

Is the client able to answer simple social questions (i.e.: name, age, address)

Is the client able to respond to simple 'wh' questions (Yes/No)? (e.g.: What color is that ball? Where are your shoes?)

Does the client ask 'wh' questions for information (Yes/No)? (e.g.: Who is that boy/girl?)

Does the client initiate a conversation around specific topic (Yes/No)? (e.g.: trains, movies, sports)

Does the client maintain appropriate proximity to conversation partners (Yes/No)? (arm's length away)

Does the client pay attention to others nonverbal language and understand what is being communicated (Yes/No)? (e.g.: hand signals, body language)

Does the client follow group routine/activities (Yes/No)?

Does the client make transitions to the next activity when directed (Yes/No)?

Does the client accept interruptions or unexpected changes (Yes/No)?

Does the client respond to interactions from peers (Yes/No)? (e.g.: physically accept items from peers, answers questions)

Does the client interact cooperatively with peers (Yes/No)? (e.g.: playing games with rules, participating in extracurricular activities, engaging in hobbies?)

If the client is a child, does the client play with other children, such as sharing toys and talking about the play activities even though the play agenda of children by be different (Yes/No)?

Does the client get uncomfortable when left to their own self-direction, or during unstructured activities?

Does the client demonstrate aggressive behavior towards others (Yes/No)?

Does the client have the ability to calm him/herself when upset (Yes/No)?

Does the client have the ability to calm him/herself when their energy level is high (Yes/No)?

Does the client use an acceptable way to express anger or frustration (Yes/No)?

Does the client enjoy any hobbies or sports (Yes/No)?

General Information

Please tell us the positive strengths and attributes you see in the client:

Please describe any other information that you feel may be pertinent to the client's care:

3. Client's Education History

Communication Needs

What is the client's preferred spoken language?
Choose One
If "Other" language, which one?

Do you have any special communication needs? (Check all that apply.)

- ☐ No special communication needs.
- ☐ TDD/TTY Device
- ☐ Sign Language Interpreter
- ☐ Other assistive technology
- ☐ Assistive Listening Device
- ☐ Language Interpreter Services needed/other spoken language

Describe the Language Interpreter Services needed.

Education

At what age did the client begin school?

What is the client's highest level of education? (Please check all that apply.)

- ☐ Currently in school – K - 6th grade
- ☐ Currently in school – 7th - 12th grade
- ☐ Currently homeschooled – K - 6th grade
- ☐ Currently homeschooled – 7th - 12th grade
- ☐ Completed less than high school
- ☐ Completed high school or GED
- ☐ Completed some college
- ☐ Currently in training program
- ☐ Currently in special education
- ☐ Currently attending college
- ☐ College graduate
- ☐ Other education

If you chose "Other education", please describe.

Potential Barriers to Learning

Does the client have any barriers to learning? (Choose one)

- ☐ Inability to read or write

☐ No, there are no barriers to learning.
If there are any other barriers to learning, please describe.

Does the client have a history of learning difficulties? (Check all that apply.)

☐ No, there is no history of learning difficulties

☐ Yes, and it resulted in special school placement.

If you chose "Yes", what type of Special school placement?

☐ Yes, the client has a learning disability.

If you chose "Yes", what type of learning disability?

☐ There is some other difficulty (Other)
If there are "Other" learning difficulties, please describe.

Are there any other potential barriers to services at Learning Dreams due to the client's age or culture, language, gender, or physical condition? (Yes/No). If you chose "Yes", please describe.

4. Client's Therapy History

Current Therapy

Does the client receive any of the following services? (CHECK ALL THAT APPLY.)

☐ OCCUPATIONAL THERAPY

If receiving Occupational Therapy, is it provided by a SCHOOL or a PRIVATE THERAPIST/AGENCY?

What is the name of the Occupational Therapist? The agency? How many sessions per week? How long is each session?

☐ PHYSICAL THERAPY

If receiving Physical Therapy, is it provided by a SCHOOL or a PRIVATE THERAPIST/AGENCY?

What is the name of the Physical Therapist? The agency? How many sessions per week? How long is each session?

☐ SPEECH THERAPY

If receiving Speech Therapy, is it provided by a SCHOOL or a PRIVATE THERAPIST/AGENCY?

What is the name of the Speech Therapist? The agency? How many sessions per week? How long is each session?

☐ SPECIAL EDUCATION

If receiving Special Education, is it provided by a SCHOOL or a PRIVATE TEACHER/AGENCY?

What is the name of the Special Education teacher? The agency? How many sessions per week? How long is each session?

☐ ABA SERVICES

If receiving ABA Services, is it provided by a SCHOOL or a PRIVATE AGENCY?

What is the name of the Special Education provider? The agency? How many sessions per week? How long is each session?

☐ OTHER THERAPY/SERVICE

If receiving “Other” therapy/services, please describe:

If receiving “Other” therapy/services, is it provided by a SCHOOL or a PRIVATE AGENCY?

What is the name of the “Other” therapy/services provider? The agency? How many sessions per week? How long is each session?

Evaluation History

Has the client previously had an evaluation?

If "Yes", when and where was the previous evaluation?

Did a licensed therapist do the evaluation?

Has the client previously had a Special Education evaluation?

If "Yes", did it result in an IEP? And if so, when was that?

What IEP services did you receive?

5. Client's General Medical History

Please complete as much as possible.

The more details we have about the client's medical history, the better we can help them.

Overall Health

Please explain the client's past medical, physical, psychiatric symptoms. List any physical limitations, illnesses, diagnoses, and/or medical concerns.

☐ CLIENT HAS NO KNOWN MEDICATION OR FOOD ALLERGIES (Check here if this is true.)

Please list all food or medication allergies.

Does the client have seizures? (Yes or No)

Hearing

Do you have concerns regarding the client's hearing? (Yes or No)

Does the client have a history of frequent ear infections? (Yes or No)

If yes, number of ear infections per year.

Has the client's hearing been tested? (Yes or No)

If "Yes", When? Where? And what were the results of the hearing test?

Does the client wear hearing aids, use an FM system or have a cochlear implant? (Yes or No)

If "Yes", what kind?

Medications

Please list or include a copy of the client's current medications, including prescriptions, over-the-counter, herbal and vitamins.

☐ The client is taking NO medications at this time.

Medication 1: Name

Medication 1: Please describe: A) the purpose of this medication B) the Dosage/Route/Frequency C) Prescribed by/Date Prescribed

Medication 1: Is this taken as prescribed?

Medication 2: Name

Medication 2: Please describe: A) the purpose of this medication B) the Dosage/Route/Frequency C) Prescribed by/Date Prescribed

Medication 2: Is this taken as prescribed?

Medication 3: Name

Medication 3: Please describe: A) the purpose of this medication B) the Dosage/Route/Frequency C) Prescribed by/Date Prescribed

Medication 3: Is this taken as prescribed?

If there are additional medications, please A) Provide the name, B) describe the purpose of this medication C) describe the Dosage/Route/Frequency D) provide the Prescribed by/Date Prescribed and E) if you take your medication as prescribed.

Does the client feel like the current medications are working? If NO, please explain which medications they feel are not working and why.

Vision

Has the client's vision been tested? (Yes or No)

If "Yes", When? Where? And what were the results of the vision test?

Does the client wear glasses or contact lenses? (Yes or No)

Developmental Milestones

At what age did the client begin social smiles?

At what age did the client begin sitting?

At what age did the client begin walking?

At what age did the client begin talking?

Sleep

Does the client experience difficulty sleeping? (Yes or No)

If "Yes", please describe.

Sensory Processing

Do any of the following statements describe the client? (Check all that apply.)

- ☐ Client expresses distress during grooming (for example, fights, cries during haircutting, washing face, fingernail cutting).
- ☐ Client fears heights.
- ☐ Client seeks all kinds of movement and this interferes with daily routines (for example, can't sit still, fidgets).
- ☐ Client jumps from one activity to another so that it interferes with play.
- ☐ Client is distracted or has trouble functioning if there is a lot of noise around.
- ☐ Client has poor endurance/tires easily.
- ☐ Client responds negatively to unexpected or loud noises (for example, cries or hides at noise from vacuum cleaner, dog barking, hair dryer).
- ☐ Client watches everyone when they move around the room.
- ☐ Check this box the Client has not been hospitalized or entered into any treatment facilities.

Hospital/Facility 1: Name of Hospital/Facility, Dates of Service (From-To) and Reason (suicidal, depressed, etc.)

Hospital/Facility 2: Name of Hospital/Facility, Dates of Service (From-To) and Reason (suicidal, depressed, etc.)

Hospital/Facility 3: Name of Hospital/Facility, Dates of Service (From-To) and Reason (suicidal, depressed, etc.)

Have you been previously diagnosed by a professional (Yes/No)? If "Yes", please explain.

6. Client's Birth History

- [ ] Birth History Unknown (And please skip to the next form.)

Mother's length of pregnancy with this child client (in weeks)?

Did mother experience any of the following during pregnancy? (Check all that apply)

- [ ] Excessive Illness
- [ ] Emotional Upsets
- [ ] Exposure to drugs/alcohol
- [ ] Exposure to trauma or abuse
- [ ] Flu
- [ ] Injury during pregnancy
- [ ] Marked Swelling of Hands/Feet
- [ ] Bleeding/Spotting
- [ ] Rh Incompatibility

Condition of infant immediately after birth (Check all that apply.)

- [ ] Normal, no problems
- [ ] Difficulty with feeding, sucking, swallowing
- [ ] Breathing problems
- [ ] Jaundiced
- [ ] Birth Injury
- [ ] Congenital differences

Did any of the following occur during infancy? (Check all that apply.)

- [ ] None of these apply
- [ ] Excessive crying
- [ ] Difficulty feeding/sucking/swallowing
- [ ] Injury during infancy
- [ ] Breathing problems/ respiratory illness
- [ ] Other

If "other", please describe:

Financial Agreement

Learning Dreams LLC Educational and Therapeutic Center

5103 West Pierson Road, Suite 3, Flint, Michigan 48504
Phone: (810) 391-2923 / Fax: (810) 391-2968

LEARNING DREAMS LLC IS HEREINAFTER REFERRED TO AS THE “FACILITY

Client's Full Name

... AND IS HEREINAFTER REFERRED TO AS “CLIENT”.

Parent's or Guardian's Full Name

... AND IS HEREINAFTER REFERRED TO AS “FINANCIALLY RESPONSIBLE PERSON”.

Payments

Client and Financially Responsible Person agree jointly and separately to assume and be liable for all charges of whatever nature incurred by or on behalf of Client and to pay such charges as they become due.

Client and Financially Responsible Person further agree that if the services rendered by Facility to Client are covered by insurance, or benefits under either Title XVIII or Title XIX of the Medicare Act (Medicare/Medicaid), it is nevertheless the joint obligation of Client or Financially Responsible Party to pay all charges incurred by or on behalf of Client. Client and Financially Responsible Person further agree that any co-insurance or deductible obligation under Medicare, Medicaid, or private insurance must be paid by Client or Responsible Person.

• Client responsibility is due upon receipt of insurance explanation of benefits (EOB). Because it is extremely impractical or difficult to ascertain all items of damage or amounts thereof which would be sustained by Facility as a result of an account becoming delinquent, Client and Financially Responsible Person agree that any charges which are not paid in FULL when due shall be subject to a late fee. If balance remains unpaid 30 days after date of EOB a $35.00 late fee will be charged and account may be transferred to Transworld Systems Inc. Should Client’s account be referred to an attorney for collection, Client and Financially Responsible Person agree to pay, in addition to all sums due, all reasonable attorney’s fees, court costs, and all reasonable costs of collection.

• Client certifies and warrants that all information submitted by him for purposes of applying for or receiving benefits under Title XVIII or Title XIX of the Social Security Act (Medicare/Medicaid) is true and correct. Client and Financially Responsible Person agree to indemnify and hold harmless Facility from and against any and all loss, damage, cost, expenses or liability resulting from Client’s submission of false or incorrect information to Facility. The Client authorizes any health care facility or doctor to furnish to Facility and/or the Social Security Administration, its fiscal intermediaries or carrier all requested information from Client’s medical or financial records. Client further authorizes Facility to disclose all or any part of Client’s medical or financial records to any person or entity which is or may be liable under contract to Facility, Client, or to a family member or employer of Client to pay all or a portion of the costs of care provided to Client, including, but not limited to, hospital or medical service companies, insurance

companies, Worker's Compensation carrier, welfare fund or Client's employer. Client further authorizes Facility to disclose all or any part of Client's medical or financial records to any independent auditor of Facility. Client requests that payment of authorized benefits be made to Facility on his behalf.

• FACILITY DOES NOT MAKE ANY ASSURANCE OF ANY KIND WHATSOEVER THAT CLIENT'S CARE WILL BE COVERED BY MEDICARE/MEDICAID OR PRIVATE INSURANCE COMPANIES, and the Client and Financially Responsible Person hereby release Facility, its agents, servants and employees from any liability or responsibility in connection with the Client's and/or Financially Responsible Person's potential claim of coverage under Medicare/Medicaid or insurance companies.

• In this agreement, whenever the context so requires, the masculine gender includes the feminine and/or neutral and the singular number includes the plural.

Agreement To Treat

Patient Care

The Facility shall provide services and materials in compliance with the orders of Client's attending physician. Administration of Therapy Treatments will be delivered as ordered by said physician.

• The Facility welcomes all person without regard to race, color, national origin, religion, sex, or qualified handicaps.

• The Facility shall provide services and materials in compliance with the orders of Client's attending physician. Administration of treatments will be ordered by said physician.

• CONSENT TO TREATMENT: Client and Financially Responsible Person acknowledge that Client is under the medical treatment and care of said attending physician, and that the Facility renders its services to Client under the general and specific instructions of said physician. Client and Client Representative recognize that said physician furnishing services to Client is an independent Contractor and is not an employee or agent of Facility.

• RESTRICTIONS AND LIABILITIES: The Facility shall incur no liability for injuries of any kind suffered by Client while under its care, therefore should the Client discontinue treatment before the attending physician has so ordered Client, Client and Client. Representative agrees to assume all responsibility for all results which may follow.

• Facility is not liable for injury to Client caused by visitors attempting to assist or treat Client in any way. For the safety of Client and others, only the Client and Client's guardian, if a minor, are permitted in Client treatment areas.

• The Facility shall not be responsible for personal belongings left in the Facility.

• The Clinic may take photographs and/or videos of the Client necessary for identification and/or medical purposes at any time during the Client's Therapy Program. The Client has the right to privacy. Photographs and/or videos cannot be used for any other purposes without the Client's express written permission (signed Consent to Use Photo Image).

• In this agreement, whenever the context so requires, the masculine gender includes the feminine and/or neutral and the singular number includes the plural.

THE FINANCIALLY RESPONSIBLE PERSON OR OTHER PERSON WHO SIGNS THIS AGREEMENT ON BEHALF

OF AND IN THE PLACE OF THE Client REPRESENTS THAT HE IS AUTHORIZED BY Client TO DO SO, AND THE ABOVE NAMED Client AND FINANCIALLY RESPONSIBLE PERSON SIGNING THIS AGREEMENT AGREES BY SO SIGNING TO ACCEPT ALL OF THE TERMS HEREOF AND TO PERFORM ALL OBLIGATIONS HER UNDER. THERE ARE NO REPRESENTATIONS MADE BY FACILITY OR ANY OF ITS EMPLOYEES OR AGENTS OTHER THAT ARE SET FORTH IN THIS AGREEMENT.

THE CLIENT AND FINANCIALLY RESPONSIBLE PERSON CERTIFY THAT EACH OF THEM HAS READ THIS AGREEMENT AND RECEIVED A COPY THEREOF AND UNDERSTAND AND AGREES TO ALL THE PROVISIONS IN THIS AGREEMENT.

8. Required Insurance Waiver

Signature Required By All Insured Clients

Regardless if claims are or are not submitted.

I understand that as a courtesy, Learning Dreams Educatinal and Theraputic Center as contacted my insurance company to see what BEHAVIORAL MEDICINE AND THERAPY SERVICES BENEFITS apply to my plan.

Please note that BENEFITS QUOTED ARE NOT A GUARANTEE OF PAYMENT and may sometimes be misquoted over the phone. I DO NOT HOLD LEANRING DREAMS LLC RESPONSIBLE FOR THE INFORMATION RECEIVED.

Due to the national coding laws, we MUST bill your insurance company the day of your child's visit and under the ICD-10 code provided by your physician. If your insurance does not cover some or all of these charges you will be billed directly for the balance they indicate as 'patient responsibility' when you receive your E.O.B. (Explanation of Benefits) from your insurance company. Please DO NOT ask us to re-bill your insurance by changing the procedure or diagnosis codes.

Final decision on benefits is determined when a claim is submitted and either paid or denied. The contract with the insurance company is between the company and me; Learning Dreams is not involved and does not accept responsibility for negotiation settlement of a disputed claim. In addition, we will not await payment/resolution from third party liability carries or from a carrier with whom Learning Dreams does not have a contract for the date of service.

I understand that my insurance company MAY NOT consider the behaivioral medicine and theraputic services provided by Learning Dreams to be a covered medical expense.

I understand that even when services are listed as being a covered medical expense on my insurance plan, payment is not guaranteed. Upon receipt of claims for services rendered, my insurance company will complete a review of medical necessity and based on that review (related specifically to my child) the services may not be considered to be medically necessary or may be considered as non-covered expenses and may not be paid by my insurance company.

I elect to have Learning Dreams to provide services for my child. I understand that if my insurance company does not allow benefits or approve payment of claims for services my child has received, I am responsible for all incurred charges and I agree to pay the balance in full. I hereby authorize payment from my insurance company directly to Learning Dreams LLC for services provided.

• Insurance co-pays are due at the time of service.

• I understand that I am responsible for payment of my account on a timely basis, whether payments are made by me or by my insurance company.

• If claims are submitted to insurance and payment is not received within 45 days, I agree to follow up with the insurance company regarding payment and personally make regular payments to Learning Dreams on my account.

• All charges are due in full at time of service unless a separate payment arrangement has been approved and signed by both Learning Dreams and myself.

• In the event that my insurance company denies payment, I am fully and directly responsible for the payment of all charges. My portion of the bill is due upon receipt of the statement.

• Patient balances unpaid over 90 days will be sent to collections.

9. Authorization / Consent for Release of Client's Records

Learning Dreams LLCEducational and Therapeutic Center

5103 West Pierson Road, Suite 3, Flint, Michigan 48504
Phone: (810) 391-2923 / Fax: (810) 391-2968

Purpose of Authorization

As a parent or guardian you have the right to give permission or not give permission for the exchange of the client's records with other persons or agencies. This form provides you the opportunity to approve or not approve such a request.

From: Learning Dreams LLC, 5103 West Pierson Road, Suite 3, Flint, Michigan 48504
Phone: (810) 391-2923 / Fax: (810) 391-2968

Client's Full Name

Client's Birth Date

Parent(s) or Guardian(s) Full Name

List providers that may be contacted by Learning Dreams LLC for records & medical info (Physicians, other therapy providers, schools, hospitals, etc.)

Provider or Agency Name 1

Provider 1: Full Address

Provider 1: Phone Number and Fax Number

Provider or Agency Name 2

Provider 2: Full Address

Provider 2: Phone Number and Fax Number

Check all records types to be released:

- ☐ Assessments/Reports/Evaluations
- ☐ Health/Medical Records
- ☐ Psychological/Counseling Records
- ☐ Other type of record

If "Other" type of record, please describe:

The reason for disclosing the record(s) is (Check all that apply):

☐ Continuation of care/therapy

☐ Other reason

If "Other" reason, please describe:

All information obtained will be kept private and used only for the planning of services or for billing for services provided from Learning Dreams LLC.

NOTE: For release of medical records, the authorization will automatically expire 90 days from the date of signing.

I understand that my consent for the release of records is voluntary, and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent form release.

I declare the foregoing information is true and correct.

10. Consent to Use Photo Image

Learning Dreams LLC Educational and Therapeutic Center

5103 West Pierson Road, Suite 3, Flint, Michigan 48504
Phone: (810) 391-2923 / Fax: (810) 391-2968

Learning Dreams, LLC may take photographs and/or videos of the Patient necessary for identification and/or medical purposes at any time during the Patient's Therapy Program. The Patient has the right to privacy. Photographs and/or videos cannot be used for any other purposes without the Patient's express written permission (signed Consent to Use Photo Image).

I understand that Learning Dreams, LLC is undertaking initiatives to promote the clinic and its programs. I wish to assist in these efforts and herby grant Learning Dreams permission.

In signing the Consent, I understand and acknowledge that:

• The client's photograph may be used by Learning Dreams Educational and Theraputic Center in electronic communication productions and publication for instructional, informational, promotional or other purposes.

• I have read this Consent to Use Photo Image in its entirety and understand it prior to executing it.

Client's Full Name

Confirm Your Relationship to Client (Choose One):

☐ I hereby certify that I am the parent and/or guardian of the client named above.

☐ I hereby certify that I am the client named above.

Affirm or Deny Consent (Choose One):

☐ I DO herby give my consent, without reservations, to the foregoing on behalf of the client.

☐ I DO NOT herby give my consent, without reservations, to the foregoing on behalf of the client.

11. Notice of Consumer Rights & HIPPA Policies

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.

Effective: April 14th, 2003

Understanding Your Health Record / Information

Each time services are initiated, a record of your stay is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

• basis for planning your care and treatment
• means of communication among the many health professionals who contribute to your care
• legal document describing the care you received
• means by which you or a third-party payor can verify that services billed were actually provided
• a tool in educating health professionals
• a source of information for public health officials who oversee the delivery of health care in the United States
• a source of data for Clinic planning and marketing
• a tool for us to assess and continually work to improve the care we give and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing the disclosure of health information to others.

Our Responsibilities

The Clinic is required to:

• maintain the privacy of your health information
• abide by the terms of this Notice
• provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you
• accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will give you a revised Notice.

We will not use or disclose your health information without your authorization, except as described in this Notice.

How We Will Use or Disclose Your Health Information

1) TREATMENT: We will use your health information for treatment. For example, information obtained by a nurse, nurse assistant, physician, and other members of your health care team will be recorded in

your medical record and used to help determine your treatment. Your physician will document in your record what he or she expects from the other members of your health care team. Members of your health care team will record the actions they take and their observations of you. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you have been discharged from the Clinic.

2) PAYMENT: We will use your health information to obtain payment for our services. For example, a bill may be sent to you or a third-party payor, such as Medicare, Medicaid, or a private insurance company. The information on or accompanying the bill may include information that identifies you, such as your Social Security Number and your Medicare Number, as well as your diagnosis, procedures, and the supplies used in treating you.

3) HEALTHCARE OPERATIONS: We will use your health information for regular health care operations. For example, members of the Clinic staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

4) BUSINESS ASSOCIATES: There are some services provided in our organization through contacts with third parties, called business associates. Examples include our accountants, consultants, and attorneys. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require each business associate to sign a contract agreeing to appropriately safeguard your information.

5) DIRECTORY: If the Clinic has a posted directory, we will list your name and room number but only if you authorize us to do so. We may use your name and location in the Clinic in a printed Room Roster, unless you tell us not to. This information may be provided to people who ask for you by name, unless you tell us not to. We may also use your name on a name plate next to or on your door in order to identify your room, unless you tell us not to.

6) COMMUNICATION WITH FAMILY: Unless you tell us not to we may, using our best judgment, disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

7) NOTIFICATION: Unless you tell us not to, we may use or disclose your health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care of your location and general condition. If we are unable to reach any of those people, then we may leave a message for them at the phone number that they have given us, for example, on an answering machine.

8) PUBLIC HEALTH ACTIVITIES: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

9) FOOD AND DRUG ADMINISTRATION (FDA): We may disclose to the FDA health information about adverse events regarding FDA regulated products or activities for the purpose of activities related to quality, safety, or effectiveness.

10) ABUSE, NEGLECT OR DOMESTIC VIOLENCE: We may disclose your health information to protective services or any other government agency if we believe you have been a victim of abuse, neglect, or domestic violence. We will tell you or your personal representative that we made this disclosure unless,

in our professional judgment, we believe telling you or your personal representative would place you at risk of serious harm.

11) HEALTH OVERSIGHT AGENCIES: Federal and state law require us to disclose your health information to appropriate health oversight agencies or public health authorities responsible for ensuring the Clinic complies with applicable laws.

12) LAWSUITS: We may disclose your health information in a lawsuit or administrative proceeding in response to a court order or subpoena.

13) LAW ENFORCEMENT: We may disclose your health information for law enforcement purposes as required by law or in response to a subpoena, warrant, or summons.

14) CORONERS: We may disclose your health information to a coroner or medical examiner consistent with applicable law.

15) FUNERAL DIRECTORS: We may disclose your health information to funeral directors consistent with applicable law.

16) ORGAN PROCUREMENT ORGANIZATIONS: If you have told us of your wish to be an organ donor, we may disclose your health information, consistent with applicable law, to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

17) THREAT TO HEALTH OR SAFETY: We may disclose your health information, consistent with applicable law, if we believe in good faith the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

18) CORRECTIONAL INSTITUTION: We may disclose your health information necessary for your health and the health and safety of other individuals to the institution or its agents if you are an inmate of a correctional institution.

19) WORKERS' COMPENSATION: We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

20) AUTHORIZATIONS: We will disclose your health information as instructed in a written authorization signed by you or your legal representative. You may revoke your authorization in writing at any time.

21) OTHER: We may disclose your health information as otherwise required by law.

Your Health Information Rights

Although your health record is the physical property of the Clinic, the information in your health record belongs to you. You have the following rights:

• You may request that we not use or disclose your health information for a particular reason and/or to a particular family member, other relative, or close personal friend. We ask that such requests be made in writing on a form provided by the Clinic. Ask for Addendum P (Addendum Q in California) to the Admission Handbook. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it unless we agree to the restriction. For more information about this right see 45 Code of Federal Regulations (C.F.R.) § 164.522(a).

• If you are dissatisfied with the way or the place where you are receiving communications from us about your health information, you may request that we give you the information by another way or at another place. That request must be made in writing and given to the Clinic's Privacy Officer. Ask for Addendum P (Addendum Q in California) to the Admission Handbook. We will try to comply with all reasonable requests. For more information about this right see 45 C.F.R. § 164.522(b).

• Unless otherwise limited by law you may look at and/or obtain copies of health information about you contained in your medical record, which will be provided to you in the time frames established by law. If you request copies we may charge you a fee of $.25 per page. For more information about this right see 45 C.F.R. § 164.524.

• If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may ask us to correct the existing information or add the missing information. Those requests must be made in writing and must provide a reason for making the amendment. We ask that you use the form provided by our Clinic to make those requests. Ask the Clinic Privacy Officer for assistance in obtaining this form. For more information about this right see 45 C.F.R. § 164.526.

• You may request a written accounting of disclosures of your health information made by us during the time period for which you request. The time period may not begin before April 14, 2003 and may not be for a period of more than six years. We ask that those requests be made in writing on a form provided by the Clinic. Ask for HIPAA Form 2. Please note that an accounting will not apply to any of the following types of disclosures: disclosures made for reasons of treatment, payment, or health care operations; disclosures made to you, your legal representative, or any other person involved with your care; disclosures made pursuant to an authorization; disclosures made for listing in the Clinic Directory; disclosures incidental to an otherwise permitted use or disclosure; disclosures to correctional institutions or law enforcement officials; and disclosures for national security purposes. You will not be charged for your first accounting requested in any 12 month period. However, for any requests that you make after that, you will be charged a reasonable cost-based fee. For more information about this right see 45 C.F.R. § 164.528.

• You have the right to obtain a paper copy of our Notice of Information Practices upon request.

• You may revoke an authorization to use or disclose health information. If you revoke an authorization, the revocation will not apply to action that has already been taken. Revocations must be made in writing and given to the Clinic Privacy Officer.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Clinic Privacy Officer at the Clinic's phone number.

If you believe that your privacy rights have been violated, you may file a concern with us. You can tell the Clinic Privacy Officer about your concern by filling out the Clinic's Concern/Comment Form. You can get the form from the Clinic Privacy Officer or the Executive Director. You should give your written concern to the Clinic Privacy Officer at the Clinic's address. You may also file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services (OCR). All complaints filed with the OCR must meet the following requirements:

• Be in writing, either on paper or electronically.

• Give the name of the company you are complaining about. Describe what the company did, or did not do, that you believe violates the Health Insurance Portability and Accountability Act privacy rules. Be submitted to OCR within 180 days of when you knew, or should have known, of the alleged violation. The OCR may waive the 180 day requirement if you ask and have a good reason.

The mailing address is:

Office of Civil Rights

U.S. Department of Health & Human Services Sixth

200 Independence Avenue, S.W.
Washington, D.C. 20201

The Clinic will not retaliate against you for filing a concern with the Clinic or Company Privacy Officer or for filing a complaint with the OCR.

13. Our Policies & Procedures

Learning Dreams LLC Educational and Therapeutic Center

5103 West Pierson Road, Suite 3, Flint, Michigan 48504
Phone: (810) 391-2923 / Fax: (810) 391-2968

Policies & Procedures - Effective June 1, 2018

Learning Dreams would like to welcome you to our facility. We are pleased that you have chosen us to provide care to your child. The following is a summary of our policies for our program. Please retain this information for future reference.

DRIVE TIME:
If you choose to receive therapy services in your home, your clinician will charge the hourly private rate for drive time to and from the clinic in fifteen minute increments. The private pay is $200 per hour. If it is the case that your insurance company does not cover drive time, these charges will be the direct responsibility of the client. These fees will be billed to you at the end of each month.

MILEAGE:
Mileage for our therapy services is charged directly to the patient and is not covered by insurance. The current mileage reimbursement is $0.55/mile from the clinic to your place of residence.

ATTENDANCE:
In order for patient to receive the maximum benefit from therapy services, it is important that you attempt to keep all scheduled appointments. We understand that there may be times that attendance is not possible (illness, family emergency). However, THE PATIENT MUST ATTEND AT LEAST 80% OF THEIR SCHEDULED THERAPY SESSIONS OVER A THREE MONTH PERIOD (10/12 SESSIONS) OR RISK BEING REMOVED FROM THE SCHEDULE. Some insurance companies may deny coverage due to a pattern of poor attendance. If you miss a scheduled appointment please work with your therapist to schedule a make-up session. Please be mindful of this when scheduling vacations and other appointments.

1. Illness:

If the patient is sick or has a fever please reschedule your session. If you or your child has experienced vomiting or diarrhea, please make certain you or child have been symptom free for at least 24 hours before scheduling a session. If you are scheduled for an in home session and someone in the household is sick please work with your therapist to reschedule.

☐ I CONFIRM I UNDERTAND THE ILLNESS PROVISION

2. Cancellations:

In the event that the client is ill or if there is a family emergency, please contact your therapist or call Learning Dreams as soon as you are able to do so. ‘Late Cancellations’ (cancellations LESS than 24 hours prior to the scheduled therapy visit) are costly to our office and will be charged directly to the patient at the therapist’s hourly rate. Your insurance company does not cover cancellation fees.

☐ I CONFIRM I UNDERTAND THE CANCELLATIONS PROVISION

3. Late Arrival:

If you arrive for your appointment 15 or more minutes late, you will be billed directly for that time at the

hourly rate of your therapist. This fee will be included in your invoice at the end of the month. Your insurance company does not cover late fees.

☐ I CONFIRM I UNDERTAND THE LATE ARRIVAL PROVISION

4. Late Pick Up:

Our therapists often have back to back appointments scheduled and therefore it is important that you arrive on time to pick up your child. In the event that you arrive 5 or more minutes late to retrieve your child, you will be billed directly for that time at the hourly rate of your therapist. This fee will be included in your invoice at the end of the month. Your insurance company does not cover late fees.

☐ I CONFIRM I UNDERTAND THE LATE PICK-UP PROVISION

5. No Shows:

If you fail to keep a scheduled appointment and have not cancelled you will be charged directly at your therapist's hourly rate. Your insurance company will not cover no show fees.

☐ I CONFIRM I UNDERTAND THE NO SHOWS PROVISION

6. Consumer Rights:

I have been offered a copy of Learning Dreams' Consumer Rights and HIPPA Policies.

☐ I CONFIRM I UNDERTAND THE NO CONSUMER RIGHTS PROVISION

COMMUNITY OUTINGS:
If the patient is working on social or behavioral goals, some sessions may take place outside the patient's residence in a community setting (i.e. park, grocery store, etc.). Your therapist may not drive to the location with your child in the car. If a session is to take place in a community setting, you will meet your therapist at the designated location agreed upon.

INCLEMENT WEATHER/HOLIDAYS:
Home sessions will not take place on days when the clinic is closed due to severe weather or holidays. Your therapist will work with you to let you know what days they will not be available.

PARENT OR GUARDIAN SUPERVISION:
A parent, adult family member (i.e. aunt, uncle, grandparent), guardian, or respite care provider must be present for the duration of every session.

14. Final Authorizations And Releases

Learning Dreams LLC Educational and Therapeutic Center
5103 West Pierson Road, Suite 3, Flint, Michigan 48504
Phone: (810) 391-2923 / Fax: (810) 391-2968

Confirmations

Full name of person who completed these forms:

What's your relationship to the client? (Self, Parent, Guardian, Spouse, Sibling, etc.)

Insurance Information: Assignment & Release

I hereby authorize Learning Dreams LLC to release any information required by appropriate agencies or insurance companies. I understand that as a courtesy Learning Dreams has contacted my insurance company to see what Neurodevelopmental Benefits apply to my plan and I do not hold Learning Dreams LLC responsible for the information received. I also authorize my insurance benefits to be paid directly to Learning and I am financially responsible for any unpaid balance.I declare the foregoing information is true and correct.

By signing this I acknowledge that I've read, fully understand and agree to all information contained here.

Sign Your Name: _____

Print Your Name: _____