Dear Parents/Guardians,

Welcome to the Rochester Center for Children/Rochester Center for Autism! We are grateful that you are interested in our program and look forward to meeting you and your family. The Rochester Center for Children/Rochester Center for Autism opened its doors in Rochester, MN in April of 2004. It is a center-based ABA (Applied Behavior Analysis) program that provides one-on-one therapy for children diagnosed with Autism, as well as other Autism Spectrum Disorders. The Center looks to provide quality, caring service to each child that is enrolled. Each staff member is highly trained and dedicated to meet the needs of the families and children they serve.

The first step in enrolling in our program is completing the necessary paperwork for your child. Please thoroughly fill out each page of the client application packet that is provided below. Once you have completed the forms you may submit it by mail, drop it off or fax it to the Center. In addition to the application packet, attach all medical documentation relating to the autism diagnosis (this must include the 5 AXIS) and a copy of your child’s insurance card. I will be in contact with you when I receive the application packet to continue the intake process. If you have any questions along the way, please contact me during our scheduled business hours.

Thanks again for your interest in our program!

Sincerely,

Jaclyn Burton

Intake Coordinator/Lead Supervisor

Rochester Center for Children/Rochester Center for Autism

(507) 424-3234 fax (507) 424-3235

[jaclynburton@rcenterforchildren.com](mailto:jaclynburton@rcenterforchildren.com)

Client Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Office to complete)*

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Initial

Name Client goes by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Gender: M / F

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

**Family Information**

Client lives with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian 1**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address­­­­­­: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian 2**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: (if different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Home Phone: (if different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address­­­­­­: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information**

I give permission to The Rochester Center for Children/Rochester Center for Autism to take whatever emergency decisions are judged necessary for the care and protection of my child while at the Center.

Please provide the name and phone number of individuals who can be called in case of an emergency when parents/guardians are not available.

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

I understand that in some medical situations, the staff will need to contact local emergency resources before the parent/guardian, child’s physician and or other adult acting on the parent/guardian’s behalf.

Name of Primary Insurance: (Private or MA) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Number/MA number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Secondary Insurance: (If Primary insurance is private) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Number/MA number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I prefer: \_\_\_ Pay my balance in full at time of service

\_\_\_ Pay my balance in full upon receipt of first statement

\_\_\_ Make payment arrangements prior to services being rendered

**Assignment of Insurance Benefits**

I understand the confidentially of my records as protected by law.  Information about me/my child cannot be released without my consent.  I understand I may revoke this consent at any time, and it will automatically expire without my revocation after one (1) year from the date of signature.

I hereby give authorization for The Rochester Center for Children/Rochester Center for Autism to contact and inform my primary and secondary (if applicable) insurance companies of all medical information included in treatment plans relating to all claims for benefits submitted on behalf of myself and/or dependents.  I further expressively agree and acknowledge that my signature on this documents authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize the Insurance Companies named above to pay and hereby assign directly to RCC/RCA all benefits, if any, otherwise payable to me for his/her services.  I understand I am financially responsible for all charges incurred.  I further acknowledge that any insurance benefits, when received and paid to RCC/RCA will be credited to my account, in accordance with the above assignment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Authorized signature of Subscriber) (Date)

**Medical Information**

Hospital/Clinic Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Primary Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medication routinely taken at home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of medications to be left at RCC/RCA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# *\*\**An additional *Permission to Administer Medication* form will need to be completed and on file for each specific medication your child takes at The Rochester Center for Children/Rochester Center for Autism.

List any medical restrictions to client’s activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any special dietary needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Service Providers**

Social Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpreter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Providers** (if applicable)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_

**Therapy Options**

The Rochester Center for Children/RochesterCenter for Autism offers both in-home and center-based therapy for clients enrolled in our program. Please complete the form below to indicate which therapy you prefer for your child. The information you provide will help us to determine the type of therapy you are seeking for your child. For more specific details regarding either program you may contact the Center or go to our website at [www.rcautism.com](http://www.rcautism.com) .

Please circle:

1. What is your 1st preference?

In-Home Therapy Center-Based Therapy Combination

1. What is your 2nd preference?

In-Home Therapy Center-Based Therapy Combination NONE

1. Is there a program you would not prefer or unable to participate in?

YES NO

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Strengths**

Please list all of your child strengths such as drawing, writing, computer, etc.

|  |
| --- |
|  |

**Main Concerns**

Please list any concerns the child may have at home or in the community. This may include, but not limited to, sensitivity (i.e. oversensitive to noises, oversensitive to certain material or texture of food), behaviors, communication, social skills and play skills. Additionally, provide any special accommodations that would help staffs to better support the child’s progress.

|  |
| --- |
|  |

**Possible Reinforcers**

Please list all or any preferences that your child has shown and put \* next to the ones that are highly preferred in each category. Be SPECIFIC as possible!!

FOOD: (snacks, candies, chocolate – please be specific; kind or brand names)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TOYS: (games, stuff animals, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICAL CONTACT: (tickles, hugs, kisses, clapping, back rubs, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACTIVITIES: (reading books, listen to music, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER: (any special preferences not mentioned)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Service Coordination**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service Coordination:

Minnesota Statutes governing Children’s Therapeutic Services and Supports require providers to coordinate services. If your child is receiving any of the following, indicate the number of hours of service per day and the frequency of the service.

|  |  |  |
| --- | --- | --- |
| **Service** | **Number of Hours** | **Frequency** |
| Special Education Services |  |  |
| Child Welfare- Targeted Case Management (CW-TCM) |  |  |
| Community Alternatives for Disabled Individuals (CADI) Waiver |  |  |
| Personal Care Assistant (PCA) |  |  |
| Mental Health- Targeted Case Management (MH-TCM) |  |  |
| Recreational Therapy |  |  |
| Psychiatrist |  |  |
| Physical Therapy |  |  |
| Speech Therapy |  |  |
| Occupational Therapy |  |  |
| Collaborative/Wraparound Services |  |  |
| Family Psychotherapy Services |  |  |
| Other (explain) |  |  |

# \*\*If your family is currently not receiving Psychotherapy Services, is this something you are interested in? Please circle below.

Yes No

If no, please list reason(s) why. Circle all that apply.

Not needed at this time Busy Schedule Have tried in the past but not effective

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Release of Consent**

Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*A separate Consent for Exchange of Information form must be completed for each individual or agency you wish for RCC/RCA to communicate with.\***

* I understand that my records are protected by data practice laws and cannot be released without my consent unless otherwise allowed by law.
* I understand that only the information and records indicated below will be released or obtained.
* I understand that this consent does not authorize the recipient of the information or records to re-disclose the information or records to any other person or facility unless authorized by law.
* I understand that the information will only be used for the purposes indicated below.
* I understand that I may withdraw or modify this consent at any time but, that the revocation or modification will not affect any release of information that previously occurred.
* I understand that this consent with expire and no longer be valid **one year** from the date it was signed.
* I understand that the observation and/or assessment can take place in either setting.

**I Authorize:**

**Rochester Center for Children/Rochester Center for Autism**

**3640 9th St NW**

**Rochester, MN 55901**

Name of Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To obtain records from or release records to:**

Name of Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of information released:**

\_\_\_Assessments or evaluations \_\_\_Educational records

\_\_\_Behavior reports \_\_\_Medical records

\_\_\_All \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information may be shared in person or by mail. I also give permission to share information using the following methods:**

\_\_\_Phone \_\_\_Email

\_\_\_Fax \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_All

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian or Authorized Representatives Signature Date

Federal Law: “This information has been disclosed to you from records whose confidentiality is protected by Federal Law prohibits disclosing this material. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.”

# **Rochester Center for Children/Rochester Center for Autism Consent Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as parent/legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission for my child/ward, (hereinafter “Participant”) to participate in the Rochester Center for Children/Rochester Center for Autism Early Childhood Program. I have received an enrollment application package and have read, understood and completed all the necessary forms required prior to enrollment. I agree with the current personal development goals established for Participant, and I am aware that I will be required to attend periodic meetings for review and revision of Participant’s individual program. I also understand that I may withdraw Participant at any time. I understand that the Rochester Center for Children/Rochester Center for Autism reserves the right to terminate the enrollment of Participant for failure to adhere to program standards.

I have given all emergency contact information to the Rochester Center for Children/Rochester Center for Autism.

I also give permission for the Rochester Center for Children/Rochester Center for Autism to use any necessary information and data collected on Participant to be reviewed and used in presentations at any professional meetings and conferences. I understand that Participant’s name and identity will be kept confidential and will not be disclosed without prior written notification. I also understand that this will serve to further the advances in the field of autism.

I hereby agree to hold harmless and release from any and all liability, the Rochester Center for Children/Rochester Center for Autism, its directors, officers, employees, agents, affiliates, sponsors, and promoters, as well as, their respective directors, officers, employees, and agents (hereinafter collectively known as “the Rochester Center for Children/Rochester Center for Autism and its Sponsors”), for any injury or illness to the Participant, arising out of or in connection with his/her participation in the Rochester Center for Children/Rochester Center for Autism program. Also, to the fullest extent allowed by law, I hereby waive and discharge my and the Participant’s rights, including those of our heirs and assigns, to any and all claims of damages for injury or illness to the Participant, against the Rochester Center for Children/Rochester Center for Autism program. I agree that health insurance coverage for the Participant is my sole responsibility.

Parent/Guardian comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Name (Please Print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Signature Date

**Client Notification of Privacy Rights**

Health Insurance Portability and Accountability Act (HIPAA)

Recent federal law, the Health Insurance Portability and Accountability Act (HIPAA), has created new client protections surrounding the use of protected health information. Commonly referred to as the “ medical records privacy law,” HIPAA provides client protections related to electronic transmission of data, the keeping and use of client records, and the storage and access to health care records. HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. This Client Notification of Privacy Rights is designed to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we will do all we can do to protect the privacy of your mental health records.

HIPAA requires that we secure your signature indicating you have received or been offered the Client Notification of Privacy Rights document.

I have accepted a copy of the Client Notification of Privacy Rights document. \_\_\_\_\_\_

I have been offered a copy of the document and do not wish to have a copy at this time. \_\_\_\_\_\_

(I understand I have the right to review the document before signing this acknowledgement form.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name (print) Client or Legal Guardian Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Date of Birth Date Signed

Please sign and return this page to the office. You may retain the notification document for you records.

HIPAA Privacy Rights Notification 06-

**FACE Sheet**

Please complete the form below by providing as much information as possible regarding your child. This information will be given to medical personnel in case of an emergency.

|  |  |
| --- | --- |
| Name |  |
| Birth Date |  |
| Parent/Guardian |  |
| Home Address |  |
| Home Phone Number |  |
| Cell Phone Number |  |
| Work Phone Number |  |
| Primary Insurance | Name: |
| Member Number: |
| Group Number: |
| Secondary Insurance | Name: |
| Member Number: |
| Group Number: |
| Hospital/Clinic Preference |  |
| Primary Doctor |  |
| Allergies |  |
| Other Information |  |
| Rochester Center for Children/Rochester Center for Autism | 3640 9th Street NW  (507)424-3234 |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Signature Date

**Additional Information**

Thank you for completing the client registration packet. In addition to submitting the application packet, please include the following items when applying for enrollment:

* Copy of your child’s insurance card(s)
* Medical documentation pertaining to the diagnosis of autism
* Reports from other service providers (if applicable)
  + Speech therapy, school services, occupational therapy, etc.

Please contact the center if you have any questions when completing the application packet, or regarding the intake process.

Thanks again,

Jaclyn Burton

Intake Coordinator/Lead Therapist

Rochester Center for Children/Rochester Center for Autism

(507) 424-3234 fax (507) 424-3235

[jaclynburton@rcenterforchildren.com](mailto:jaclynburton@rcenterforchildren.com)

**Support Group**

The Rochester Center for Children/Rochester Center for Autism offers a support group for parents, guardians and others who work closely with children diagnosed with Autism.

* We welcome parents diagnosed with Autism of any age. The Autism support group looks to offer guidance, counsel, aid, comfort, understanding and bonding to all those who raise or work with children on the spectrum.
* Additionally, staff and volunteers trained by the Center provide childcare to help ensure all family members can attend. There is a small fee for utilizing the childcare services during these support groups.
* The group gathers once a month at the Rochester Center for Children/Rochester Center for Autism and is led by Edie Koch, Family Support Specialist, MHPr, an employee from the Center.
* Groups are sometimes focused on particular topics of interest (ex. how to deal with behaviors in the home) and other sessions provide an open discussion forum.

The Parent Support Groups typically run the last Wednesday of each month from 6:30-8:00. Most months during the school year a family meal is also served prior to the group to make our support groups more accessible for families. If you would like more information about the parent support group you may call the Center or contact Stephanie Schmidt at [stephanieschmidt@rcenterforchildren.com](mailto:stephanieschmidt@rcenterforchildren.com)

**Sibling Support Group**

The Rochester Center for Children/Rochester Center for Autism welcomes siblings of children with Autism Spectrum Disorders to join us for a monthly Sibling Support Group! At our sibling group, brothers and sisters will meet other siblings of children who have Autism Spectrum Disorders. They will get a unique opportunity to talk with other kids who understand what it’s like to have a sib with special needs. Most importantly, they will also have a good time!

* The group is for brothers and sisters (including step-siblings) of children who have Autism Spectrum Disorders ages 4 and up. Those who attend the group are not required to be legal siblings. Families do not need to be clients of RCC/RCA to register.
* The cost is $10 for the first child and $5 for each additional child. This fee applies for both the Sibling Group as well as the childcare group.
* There will often be an optional family meal from 6-6:30, and is made available free of cost through generous funding from the RT Autism Awareness Foundation.
* The Sibling Support Group typically runs the last Wednesday of each month during the school year from 6:30-8:00, the same time as the Parent Group. A parent does not need to be in attendance at the Parent Group for the Sib to participate in the Sibling Group.

All Sibling Group participants must RSVP by the deadline to reserve their spot. To be added to the email list to receive notifications on the Sibling or Parent Support groups, please contact Stephanie Schmidt at 507-424-3234 or by email at [stephanieschmidt@rcenterforchildren.com](mailto:stephanieschmidt@rcenterforchildren.com)

OCR HIPAA Privacy

December 3, 2002

Revised April 3, 2003

NOTICE OF PRIVACY PRACTICES

FOR PROTECTED HEALTH INFORMATION

[45 CFR 164.520]

**Background**

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

**How the Rule Works**

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity’s obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

* Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR164.500(b)(1).
* A correctional institution that is a covered entity (e.g., that has a covered health

care provider component).

* A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in plain language that describes:

* How the covered entity may use and disclose protected health information about an individual.
* The individual’s rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
* The covered entity’s legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
* Whom individuals can contact for further information about the covered entity’s privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

* A covered entity must make its notice available to any person who asks for it.
* A covered entity must prominently post and make available its notice on any website it maintains that provides information about its customer services or benefits.
* Health Plans must also:
* Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
* Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
* Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.
* Covered Direct Treatment Providers must also:
* Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual’s written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
* When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual’s first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
* In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
* Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider’s office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.
* A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

* Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.
* Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

FAQs on Notice of Privacy Practices

FAQs on ALL Privacy Rule Topics

**You can also go to** [**http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std\_alp.php**](http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php) **then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.**

