Wheels Of Wellness
Behavioral Consulting

13 Lodato Avenue
San Mateo, CA 94403

Client Information

Client Name:	DOB:	Referral source:
Address:		
Parent/Guardian:		Parent/Guardian email:
Best Contact Phone Number:		Diagnosis:
Please describe your child's strengths and interests:		
Please describe any expressive or receptive communication challenges:		
Please list the behavioral and/ or social challenges or developmental delays your child struggles the most with:	1. 2. 3. 4. 5.	

Additional Notes:				
Has your child participated in a group before?	When/where/with whom?			Describe how your child does in a group setting:
Please list any current therapies and treatment providers as well as how long your child has participated in them:				
Is your child currently on medication:	Yes	or	No	Medication list:
Please list any allergies or sensitivities your child may have:				

Anything else you'd like to share about your child?

KINDERGARTEN READINESS PROGRAM INFORMED CONSENT AND CLIENT RESPONSIBILITIES

* I understand that within certain limits, information revealed by participants in groups will be kept strictly confidential by the clinician or specialist and will not be revealed to any person outside of the group or to any outside agency without your written permission. An inherent risk with groups is the confidentiality of information disclosed, as all group members verbally agree to hold information disclosed as confidential but law and ethics do not bind this agreement.

* A licensed or certified clinician as well as unlicensed specialists may conduct groups. In some cases of therapeutic group therapy, sessions may be reimbursed by your insurance provider. Insurance carriers typically require that the dates of treatment, fees and diagnosis be disclosed. Please note: *NOT ALL GROUP SERVICES WILL BE REIMBURSABLE.*

* **There are certain situations in which as a mandated reporter, group leaders are required by law to reveal information obtained during any form of therapy to other persons or agencies.** These situations are as follows: 1) if you are a threat of grave bodily harm or death to self or another person, 2) if program we become aware of a situation of neglect or harm of a minor or an elderly individual, 3) if a court of law issues a legitimate subpoena, and/or 4) you are a court-referred client. If we believe there is risk of you harming someone else or self-inflicting harm, we have an ethical responsibility to give this information to appropriate persons in order to obtain the best care for you and those you may harm. Additionally, information may be shared with others clinicians or specialists associated with the client, all of whom are bound by the same confidentiality laws. Although the parent of a minor is the “holder of privilege,” disclosing the content of some sessions with minors to parents tends to undermine therapy in some cases. Reporting to parents is kept to general progress/issues or if the minor is involved in dangerous or harmful activities.

* Group expenses are your responsibility regardless of insurance coverage. There is no reimbursement for missed classes. The cost of the 10 week, 40 hour program is $5000 ($125.00/hour). Payment may be made in full by the start date or in two separate payments of $2500/each. Clients making two separate payments agree to commit to the entire 10 week program and are responsible for both payments per the payment schedule. The first payment of $2500 is due on **June 12, 2018** and the second payment will due: **July 17th, 2018**

* Wheels of Wellness will make its best effort to safeguard children and families while receiving services. However, WOW is not responsible for accidental injuries and

assumes no liability for injuries occurring on its premises and clients agree to hold without fault or negligence any member of WOW staff.

* In the case of an emergency, when it is the opinion of the professional staff that a child be seen by a physician, and it is not possible to reach parents or legal guardians or the child's primary care physician, an emergency arrangement will be initiated by a WOW staff member for the child to receive treatment.

* Please note that Wheels of Wellness is an interdisciplinary collective group currently comprised of multiple clinicians who are colleagues dedicated to a common therapeutic vision. These professionals provide behavioral assessments and consultation, social skill facilitation and group therapy to children and families. The professionals at Wheels of Wellness act as independent practitioners solely responsible for their own professional scope of practice and business practices. These clinicians do not operate as a formed, legal partnership, a legal corporation, LLC or any other joint business entity. **Wheels of Wellness as a collective will not be held liable for the individual practices of its members and each clinician or specialist acts independently surrounding her practice. Questions or concerns should be fielded directly to the clinician or specialist responsible for your group.**

KRP GROUP NORMS AND EXPECTATIONS

Client Expectations

1. Clients will arrive on time for session. If a client is running late, parent/guardian must contact Heather Danilovics at (916) 605-9324 or Sasha Torres at (408) 368-8176

2. Clients will use the bathroom prior to start of session.

3. Clients participating in KRP must be potty-trained.

4. If a client is sick (i.e. fever, excessive coughing, mucus, did not go to school) client will not attend the session(s).

5. Clients are not permitted to bring toys or other items to session. Water bottles and snacks are permitted for snack time.

6. If any client demonstrates behaviors that impede the safety of self or others parents will be notified immediately. The client's eligibility to continue in the program will be determined by KRG clinicians.

Parent Expectations

Parents/guardians MUST complete an intake form and sign an informed consent document for their minor child prior to participation in the KRP.

1. If parent/guardian wishes for a clinician/specialist to share information obtained in a group with another service provider a release of information form is required.

2. Parents understand that other therapeutic activities may take place in the building so anonymity is not assured and parents may not wait for their children.

3. Parents/guardians and/or authorized individuals should arrive on time to drop-off and pick-up client. If there is an emergency which causes a delay, the clinician or specialist should be notified ASAP. Additionally, clients are not permitted to leave the office with anyone not listed on the intake form as an authorized individual.

4. Parents/guardians should encourage client to use the bathroom prior to the start of session.

5. Parents/guardians are not permitted to stay during the session without making prior arrangements with the clinician or specialist, as other therapeutic activities may be taking place in the building. Some group work will have a parent component or session arranged with a

supervising clinician as part of the sessions. Email, phone or text consultation is billable at the clinician's Case Management rate of $300/hour. If you would like to arrange a session to discuss additional information about your child, please notify a clinician via email to arrange.

6. If a client is going to miss a session, the parent is responsible for notifying the clinician.

7. If a client is sick, the clinician or specialist should be notified immediately. Parents or authorized individuals should be available to pick-up clients who may become sick during group sessions.

8. KRP will provide a snack/special treat during each session. Parents/guardians will provide food and beverages for any client requiring a special snack or beverage due to allergies or dietary restrictions.

9. Parents will direct questions or concerns directly to the leaders of the group.

10. Parents and clients should arrive no more than 5 minutes prior to the start of session. Due to safety, no loitering is allowed outside the office.

11. Clinician's will provide a final progress report with future recommendations at the conclusion of the program.

NOTICE OF PRIVACY PRACTICES

1. 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.

2. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me.

3. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. **For treatment.** I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.

6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/ imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.
15. **Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer**.**
16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. **I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other heath-related benefits and services that may be of interest to you.**
18. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAAregulations.

19. If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

4. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example,

sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

5. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you

file a complaint about my privacy practices, I will take no retaliatory action against you**.**

6. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Heather Batalden, MA, LPCC 13 Lodato Avenue San Mateo, CA 94403

7. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003 and 1/18/2015.

PLEASE READ AND SIGN ATTACHED FORM.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I,_____, acknowledge that I have received a copy of WHEELS OF WELLNESS Notice Regarding Privacy of Personal Health Information.

Patient Full Name: _____

Date of Birth: _____

Signature: _____

Relationship to Patient: _____

Date: _____

KRP Group Consent

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms.

By signing this contract, I agree to the terms and conditions outlined above and authorize Wheels of Wellness to provide group services to my child and/or family. Furthermore, I agree to the financial responsibility for all services rendered per the terms described above.

Client or Child's name	Client or Child's Date of Birth
Parent/Guardian Name	Parent/Guardian Signature
Parent/Guardian Name	Parent/Guardian Signature

ALTERNATE MEANS OF COMMUNICATION CONSENT

Please check the appropriate box and initial to indicate that you have read and understand the following:

I_____authorize Heather Batalden and aforementioned Independent Contractor **to email, text or voicemail me** regarding appointment times and/or to exchange clinical information, as needed. By initialing this section you are aware of and authorize me to potentially send information that may be read or listened to by unauthorized persons, groups, companies or government agencies that Heather Batalden does not control or may not know of reading or listening to such information shared via these modes of communication. Please note: by not authorizing these methods of communication we are left with traditional US mail to communicate information.

PHOTOGRAPHY/VIDEOGRAPHY CONSENT

I_____authorize Heather Batalden and aforementioned Independent Contractor to photograph or video my child for the purpose of creating materials that support our treatment, such as visual icons, etc. My team will only utilize photographs or videos for the purpose of our benefiting our treatment and photographs and videos will be deleted after being utilizes for the purpose discussed and intended.