Wheels of Wellness
Behavioral Consulting

Client Information

Client Name:	
DOB: ______/______/______	Referral Source:
Address:	
Parent/Guardian Name (s):	
Phone:	Email:
Client's Diagnosis (if applicable):	
Please describe your child's strengths & interests:	

Please describe any expressive or receptive communication challenges:

Please list your top three concerns in the areas of behavioral, social, emotional, and/or skill-based needs:
1. **2.** **3.**

Does your child currently attend or has in the past participated in any of the following programs or support groups?

PROGRAM	Yes/No	WHERE?
Daycare		
Pre-School		
Academic Program		
Social / Emotional		

Please list any current therapies and treatment providers. Please note length of time your child has been participating in them as well.

TYPE OF THERAPY	NAME OF PROVIDER

Is your child currently taking medication? **Yes** or **No** If so, please list medications and any possible side effects of which we should be made aware of:
Do you have any upcoming vacation dates? If so, please list the dates below:
Will you need an insurance claim form? **Yes** or **No**

If your child has had a recent evaluation, please attach the report to this intake packet.

Please note anything else you would like to share about your child:

Social and Emotional Telehealth Skills Group & 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 providers 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 other 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. **Group sessions requires payment in full prior to the first session for the entire unit.** There is no reimbursement for missed classes. Should cancellation of group be required due to a clinician or specialist's absence or a therapeutic emergency, the group members will be notified in advance or another clinician or specialist will cover the group.

- Please note that Wheels of Wellness is an interdisciplinary collective group currently comprised of two clinicians Heather Batalden, MA, LPCC, Sasha Torres, MA, BCBA and other specialists, who are colleagues dedicated to a common therapeutic vision. These

professionals provide behavioral assessments and consultation, social skill facilitation via telehealth 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.**

Telehealth Group Consent

Introduction:

Telehealth involves the use of electronic audio-video communication equipment to enable remote contact with health care professionals. The purpose of telehealth is to improve patient care by providing timely and confidential access to clinicians.

Telehealth may be used to facilitate behavioral assessment and/or the delivery of direct or group therapeutic services.

Expected Benefits:

Telehealth allows for several enhancements to therapeutic service, including:

- Improved access to healthcare
- More efficient evaluation and case management
- Reductions in transportation time
- Overall reductions in healthcare costs

Potential Risks:

Any electronic transmission of personal health information comes with potential risks. These risks may include, but are not limited to:

- Poor audio/video resolution or temporary connectivity outages.
- Delays in treatment due to deficiencies or failure of telehealth equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information

Please note that the clinician or specialist will take every precaution possible to maintain the safety and confidentiality of their clients. Also, clients may withdraw from or refuse treatment via telehealth at any time or for any reason without risk of penalty or loss of service.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy of medical information also apply to telehealth and the no information obtained in the use of telehealth which identifies me or my child will be disclosed to other entities without explicit consent.

2. I understand that I have the right to withhold or withdraw my consent for the use of telehealth without risk of penalty or loss of service.
3. I understand that my clinician or specialist has the right to terminate telehealth care if she determines a risk to the client's health or if confidentiality cannot be adequately protected.
4. I understand that I may expect the anticipated benefits from the use of telehealth, but that no results can be guaranteed or assured.

By signing this form, I certify:

- That I have read this form in its entirety.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given opportunity to ask questions and that any questions have been answered to my satisfaction.

I, the undersigned, hereby authorize that I have read, understood and agree to use telehealth group services as a part of my treatment or in the treatment of my legal dependent.

____ __________________________

Signature of Patient or Authorized Guardian Date

If authorized signer, relationship to patient: ____

TELEHEALTH GROUP NORMS AND EXPECTATIONS

Client Expectations

1. Client(s) will arrive on time for the telehealth group session. If a client is running late, parent/guardian must contact team via email at wowgroups@wheelsofwellnessconsulting.com.

2. Client(s) will use the bathroom prior to start of the telehealth group session.

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

4. Client(s) are not permitted to bring toys or other items to the telehealth session.

Parent Expectations

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

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/guardians and/or other caregivers should assist and confirm that the client has WIFI connectivity and is logged into the session prior to the telehealth session starting.

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

4. Parents/guardians are not permitted to observed during the session without making prior arrangements with the clinician or specialist, as this may increase off-task behavior or maladaptive behaviors from other participants.

5. If a client is going to miss a session, the parent is responsible for notifying the clinician as soon as possible.

6. If a client is sick, the clinician or specialist should be notified immediately via email (wowgroups@wheelsofwellnessconsulting.com).

7. Payment for telehealth group services is due prior to the start of the unit. All fees must be paid for in the form of a check or via Zelle. Please confirm payment method with clinician in advance.

8. Parents will direct questions or concerns directly to the leaders of the group via email. Please note that if questions take more than 10 minutes to address, the response will be billed at the individual clinician's rate.

9. Clients should not log in to the telehealth group sessions more than 5 minutes prior to the start of the session.

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 ensure 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.

3. 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 health-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 HIPAA regulations.

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: Wheels of Wellness 1110 South. El Camino Real, Suite #3 San Mateo, CA 94402

7. EFFECTIVE DATE OF THIS NOTICE

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

Acknowledgement of Privacy Practices

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

Client's Full Name: ____

Client's Date of Birth: _______________________________________

Parent/Guardian Signature: ____________________________________

Relationship to Patient: _______________________________________

Date: ____

Telehealth Service Agreement

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

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

____
Date

Alternative Means of Communication Consent

Please fill-in your name and initial below to indicate that you have read and understand the following:

I______________________, authorize Wheels of Wellness 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 clinicians to potentially send information that may be read or listened to by unauthorized persons, groups, companies or government agencies that Wheels of Wellness 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 Wheels of Wellness is left with traditional U.S. postal service to communicate information to you.

Initials: _________________________

Photography/Videography Consent

I ______________________, authorize Wheels of Wellness to photograph or take video of my child for the purpose of creating materials that support telehealth group treatment. Wheels of Wellness will only utilize photographs or videos for the purpose of benefiting the treatment and photographs and videos will be deleted after being utilized for the purpose discussed and intended. I understand that if I send a picture or video to any clinician or specialist for the purpose of identifying a child during an observation, documentation of a behavior or any other reason, Wheels of Wellness will utilize the material only for the purpose intended.

Initials: _________________________