



Embrace Therapeutic Educational Program, LLC
5501 Fortunes Ridge Dr. Suite H Durham, NC 27713

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Welcome to Embrace. This document provides information about our business policies. Ethical and legal standards require that these policies be explained and agreed upon in writing before services begin. It contains information about the Health Insurance Portability and Accountability Act (HIPPA) – a federal law that provides privacy protections and patient rights regarding use and disclosure of your health information. It is very important that you read these policies carefully and ask for clarification when needed. After reading and agreeing to these forms, please sign and date them. You may revoke this agreement in writing at any time. We can discuss any questions or concerns you might have.

FEES: Payment is monthly prior to services, or as arranged (per semester or biweekly). We will provide an invoice. We accept cash, checks payable to Embrace and major credit cards.

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| One time, initial application fee for new students | \$50 |
| Materials fee (per semester for groups) | \$50 |
| Insurance processing fee (per semester) | \$50 |
| Social Skills group | \$40/hr |
| Homeschool Group | \$30/hr |
| 1:1 or Paired (2 children) tutoring | \$40-\$65/hour |
| Assessment/treatment planning | \$125/hour |
| Missed tutoring session (with 24 hours notice) | \$25 |
| Missed tutoring session (fewer than 24 hours notice) | full rate, no reimbursement |
| Missed group session (fewer than 30 days notice) | full rate, no reimbursement |
| Late pick up >10min (after one excused occurrence) | \$1 per minute |
| Other professional services per hour* | \$125 |
| Returned Checks | \$30 |
| Late payment fee (more than 30 days) | \$25 |

*Other professional services includes frequent telephone calls lasting longer than 10 minutes, preparation of records or treatment summaries, consulting with other professionals per your request, team meetings.

INSURANCE: Please note that Embrace is an “out-of-network” provider for insurance carriers. If you choose to file insurance, we will help you prepare paperwork needed to submit to your insurance company. Your insurance company should then mail you a check for the portion of the charges they reimburse. I strongly recommend researching details about your ABA coverage. “Out-of-network” providers and “in network” providers are sometimes reimbursed at different rates. Also, some managed care plans require authorization before you begin treatment, and may not pay for sessions held before authorization. It is helpful to find out specifics about your coverage by asking questions such as: *Is there a deductible? How many visits per year are covered? What are the dates of the benefit year?*

We will provide you with the assistance in receiving the benefits to which you are entitled; however, you are responsible for full payment of fees prior to services regardless of payment or nonpayment by the insurance company. It is important that you keep up with whether or not your insurance company is paying properly as insurance companies frequently make errors in processing claims. Also, please note that you always have the right to pay for services without seeking insurance reimbursement.

CANCELLED APPOINTMENT: Since continuity is important, we encourage you to make every effort to keep all appointments. Also, once an appointment time is scheduled, we reserve staff for these services. If you

are unable to make your appointment, please call at least 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled session fees. Late cancellations will be charged the full fee according to the fee schedule listed above. In case of emergency these fees may be waived.

WEATHER: Embrace will make every reasonable attempt to open on time and remain open during inclement weather. As we are within the Durham school district, we listen to their decisions regarding delays and cancellations, however we may make a different decision. In the case of extremely dangerous weather conditions, road conditions or states of emergency, it may be necessary for Embrace to cancel classes or delay the opening time. The decision will be emailed to parents by 6:00am or at least three hours before afternoon groups. If groups are cancelled by Embrace, we will work with the families to reschedule the session. *We cannot provide refunds or discounts if families choose to stay home when the groups have not been cancelled or if families cannot attend the make-up session.*

Should parents be prevented by weather conditions from reaching the facility to pick up their children, staff members will care for the children and maintain proper staff-child ratio until such time as the parents can safely pick up their children. Should the building require emergency evacuation, parents will be contacted by telephone as to the location of the children.

CONTACTING US: You can contact us by phone (919-213-9845) or by email at embraceautismnow@gmail.com. Please note that email is not a secure form of communication. We prefer to limit email correspondences to scheduling and administrative purposes and general updates about groups. We prefer that clinical issues be discussed in person rather than by phone.

OPERATIONAL POLICIES

Late Pick-up:

If you drop your child off more than 5 minutes before class or pick your child up more than 5 minutes after class has finished, you will be billed for extra care time at the rate of \$1 per minute. You will be billed and expected to pay by the next session that your child attends. It is important to us to recognize and respect the time and planning that the teachers have put into structuring and balancing the sessions to create smooth closings and transitions. If you would like to arrange for after class care in advance, the rate is \$15 per 30 minutes and must be requested and approved at least one week in advance. All families will be given "one free pass" per semester as we recognize that sometimes circumstances are outside of our control.

Parents:

Please be mindful of the following expectations we have for parents of children in our program. A repeated violation of these expectations will require a meeting with a director and possible termination of services.

- Please refrain from talking about other children in the program
- Please refrain from having a discussion about your or other children with staff in the waiting room
- Please bring your child on-time (not more than 10 minutes late)
- Please refrain from asking staff clinical questions right before, during or after groups. Set up a time to talk with an instructor or a director through email.
- Please refrain from any rude, judgmental or disrespectful behavior to others' families or children.

Parent Concerns:

If you have concerns about your child, their group, or the program, please contact one of the directors and ask to fill out a feedback form. We take your feedback very seriously as it helps us to always be improving, or to solve any issues that arise. A director will respond to your feedback or concerns within 48 hours.

Sick Policy:

If your child has any of the symptoms listed below, please keep them home. Also, please make sure that we know of any signs and symptoms that your child gives when he or she may be experiencing discomfort, so that we can be mindful. Many of our students have difficulty directly communicating when they feel ill. Also, please keep in mind that we do not provide refunds when children are sick.

- Diarrhea - 3 or more watery stools in a 24 hour period, especially if the child acts or looks ill.
- Vomiting - vomiting 2 or more times within the past 24 hours
- Rash - body rash, especially with fever or itching. Diaper rashes, heat rashes, and allergic reactions are not contagious.
- Appearance/Behavior - unusually tired, pale, lack of appetite, unusually confused or irritable. This is a sufficient reason to exclude a child from coming to school.
- Severe sore throat - especially with fever or swollen glands in the neck.
- Lice, Scabies - Children must not return to school until they are free of lice and nits (eggs). Children with scabies can be admitted after treatment.
- Fever - temperature of 100 degrees F (orally) or higher AND sore throat, rash, significant greenish nasal discharge, vomiting, diarrhea, earache, unusual irritability or confusion. Fever by itself is usually not sufficient
- Cough - Lasting more than one week, unless cleared by a physician.
- "Pinkeye" - Teary, redness of eyelid lining, irritation followed by swelling and yellow drainage.
- Greenish nasal discharge - lasting more than one week.

CONFIDENTIALITY: All sessions are confidential. The laws and standards of our profession require that we keep "Protected Health Information" about your child in a Clinical Record. Your Clinical Record includes information such as your reasons for seeking my services, your diagnosis, the goals that we set for treatment, your progress towards those goals, your history, any past treatment records that we receive from other providers, notes from any case consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. In general, the law protects the privacy of all communications between a client and a service provider. In most situations, we can only release information about your assessment or treatment to others with your written permission. Please note the exceptions listed on the "Notice of Privacy Policy" form. With these exceptions, we will try to discuss the situation with you before taking any action and we will limit my disclosure to what is necessary. In addition, for the purpose of case consultation, some information about aspects of our work together may be shared with other professionals, however no identifying information will be revealed. The consultant is also legally bound to keep the information confidential. I will generally not inform you about these "anonymous" consultations.

FURTHER DISCLOSURES: Federal and state law do not require patient consent for the following disclosures:

- Child abuse: We must report to the local Department of Social Services information that leads us to reasonably suspect child abuse or neglect. We must also comply with a request from the Director of the Department of Social Services to release records relating to a child abuse or neglect investigation.
- Adult abuse: We must report to the local Department of Social Services information that leads us to reasonably suspect that a disabled adult is in need of protective services.
- Judicial/Administrative Proceedings: We must comply with an appropriately issued court order or subpoena requiring that we release your PHI.
- Serious Threat to Health or Safety: We may disclose your PHI to protect you or others from a serious threat of harm.
- Worker's Compensation: Under certain circumstances, we may disclose your PHI in connection with a Worker's Compensation claim that you have filed.

- As Required by Law: There may be instances where either federal or state law requires that we release your PHI.

PATIENT RIGHTS:

- You have a right to request restrictions on certain uses and disclosures of PHI; however, federal law does not require that we comply with all requests. You can request and receive confidential communications of PHI by specified means and at alternative locations.
- You may inspect or obtain a copy of PHI in certain circumstances when requested in writing. If we deny you that right, you may have this decision reviewed. We will answer your questions concerning the details of the reviewing process. If you do receive a copy of your PHI, because these are professional records, they can be misinterpreted to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents.
- You may request an amendment of PHI so long as we maintain that PHI in our records. Federal law does not require us to agree to each such request. We will answer your questions about the amendment process.
- You have a right to receive an accounting of most disclosures of PHI for which you have not provided consent. We will answer your questions concerning the accounting process.
- You have a right to obtain a paper copy of this notice from us upon request.

QUESTIONS: If you have questions about this notice, disagree with a decision we make about access to your PHI or have other concerns, please contact us.

SIGNATURE

I have read the information contained in this document and agree to abide by its terms during our professional relationship. I understand that I am responsible for payment of fees associated with services rendered. We now accept credit card payments. Please fill out the credit card authorization form below if you would like to use a card to make a payment. If your payment is more than 30 days late, we will add a \$25 late fee, a 3.5% of the payment to cover the manual entrance fee, and your child will not be able to receive services until the payment has been made. I also understand that a one month deposit is required per semester for groups. A written 30 day notice of withdraw is required as well as payment during this period regardless of attendance. The deposit will be used to cover the balance of these 30 days, and any remaining deposit will be returned. We understand that family circumstances change, however we consider your deposit to be a commitment to a full semester. Deposits are applied to the final month's tuition.

Client's Name: _____

Signature (Parent if minor): _____

Date: _____

Photo Releases

My signature below provides consent that all photographs and/or video footage of my child be used by Embrace for the purposes of (Initial below):

_____ Public marketing (e.g. social media, flyers, brochures, webpage)

_____ Staff training

_____ Professional training (e.g. Community workshops)

_____ In house use (e.g. Emailing pictures or videos including your child to other families in the group)

Child Name

Parent Signature

Date

Credit Card Authorization Form

Today's date: _____ / _____ / _____

I, _____

as the Individual card holder, hereby authorize this card to be used for the payment required.

Credit Card Information:

Name as it appears on the Card:

Type of Card: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Number _____ - _____ - _____ Expiration Date _____ / _____

Security Code BACK of Visa OR Master Card: (3 digits) _____

Security Code FRONT of Amex Card: (4 digits) _____

Credit Card Billing Address: Street: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

Cardholder Signature: _____

Date: _____ / _____ / _____

I hereby authorize this card to be used for future deposits or payments if I have not made other arrangements for payments within 30 days of service. I agree to be charged an additional 3.5% of the payment to cover the manual entrance fee.

Please sign again for future authorization:
