



Reinforcement Unlimited, LLC

P. O. Box 1572
Woodstock, GA 30188
(770) 591-9552
ASAP@Behavior-Consultant.com

107 Weatherstone Drive #530
Woodstock, GA 30188
Fax (800) 218-8249
www.Reinforcementunlimited.com

Psychological Evaluation Intake Packet

Thank you for selecting us at Reinforcement Unlimited, LLC to help you meet the needs of your child. We know you have many options to choose from and appreciate your having selected us to assist you with this important process.

The attached packet of information will allow you time to gather information prior to your appointment that will be helpful in the evaluation of your child. If you cannot make your appointment we require 48 hours' notice (business hours) in non-emergency situations or you will be charged for the missed appointment.

Thank you for the trust that you are placing in us to assist you and your family. We understand that some of these forms may be challenging, time consuming, and in places redundant. We want you to know that the more information that we have the better able we will be to assist you and your family. If at any time in this process you have any questions please contact us.

We look forward to meeting you and your child,

Reinforcement Unlimited, LLC

att: Intake Packet

What Information Should I Bring to My Child's Evaluation?

Thank you for choosing us to conduct the comprehensive evaluation of your child. In order for us to provide you with the most accurate and complete evaluation we must have access to the developmental, treatment, medical, and educational history of your child. Without access to this information the diagnostic process is significantly restricted.

The following information needs to be provided prior to the first actual testing session with your child in order for us to be better able to select appropriate testing options for that first session. Releases are included in this packet to aid in gathering this information.

Required:

- Reinforcement Unlimited's** Intake Forms
- HIPPA Notice – Signed
- Medicaid Understanding Form – Signed
- Authorization to Evaluate Form – Signed
- Financial Information Form – Signed
- Authorization to Contact Form – Signed
- Custody Records: **If applicable** we require a copy of any custody decree in order to document who has legal rights regarding the minor child.

If you wish us to contact other agencies or individuals:

- Release(s) of Mental Health Records

If your child is receiving Special Education Services:

- Current IEP Document (and Behavior Intervention Plan – BIP – if applicable)
- Eligibility Report
- All Evaluation Reports
- Information regarding behavior and academic performance

Private Evaluations, including:

- Psychological – Psychiatric
- Neurological
- Therapy: Speech, Occupational, Physical, etc.
- Progress reports/Documentation of Goals/status report
- Other Medical Records:
 - Birth records pertaining to complications during pregnancy or after birth
 - Records of last regular visit with primary physician/pediatrician
 - Records of visits with specialists (ENT, Gastroenterology, orthopedics, developmental pediatrician, optometrist, audiology, etc.)
 - Current vision and hearing status/evaluations
 - Records of current & past medications (both prescription and over-the-counter plus "supplements" and "natural" substances)
 - Records of illnesses, surgeries, accidents, and hospitalizations

If your child has received specialized therapists, such as ABA/VBA or other therapies, we need to review summaries of those therapies.

We always appreciate the effort it takes to organize, track, and provide all this information. We will be happy to make copies at the clinic of any materials that you bring with you.

If you have any questions regarding the evaluation process, or the information contained in this handout, please contact us. Thank you!

Directions to our Offices

107 Weatherstone Drive
Suite 530
Woodstock, GA 30188
(770) 591-9552



I - 75 North

Take Exit 268 which is also known as I-575 North.

Take I-575 to Exit 7-Hwy. 92 - Alabama Road.

Turn right onto Hwy. 92 North.

3.8 Miles to a Traffic Light (1/2 Mile past Walmart & Discount Tire on Right)

Turn Left onto Weatherstone Place

IMMEDIATELY past the light turn again Left into Weatherstone Office Complex

Our Suite is in the last building on your left (just past the mailboxes on the left)

GA 400

Exit 7 to Holcomb Bridge Rd.

West to Hwy. 92 South.

Take Hwy. 92 South for about 17 miles to traffic light (Just Past Aldi on Right)

Turn Left onto Weatherstone Place

IMMEDIATELY past the light turn again Left into Weatherstone Office Complex

Our Suite is in the last building on your left (just past the mailboxes on the left)

I-575 South

Take Exit 7.

Make a left onto Hwy. 92 North - Alabama Rd NE (signs for Georgia 92 N)

3.8 Miles to a Traffic Light (1/2 Mile past Walmart & Discount Tire on Right)

Turn Left onto Weatherstone Place

IMMEDIATELY past the light turn again Left into Weatherstone Office Complex

Our Suite is in the last building on your left (just past the mailboxes on the left)

From I-75 South

Take Exit 269 or Barrett Pkwy.

Make a left.

Go to I-575 North and take Exit 7-Hwy. 92.

Turn right onto Hwy. 92 North. Alabama Rd NE (signs for Georgia 92 N)

3.8 Miles to a Traffic Light (1/2 Mile past Walmart & Discount Tire on Right)

Turn Left onto Weatherstone Place

IMMEDIATELY past the light turn again Left into Weatherstone Office Complex

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Consent and Agreement for Psychological Testing and Evaluation

I, _____, agree to allow the psychologist named above to perform the following services:

- Psychological testing, assessment, or evaluation
- Report writing
- Other (describe): _____

This agreement concerns _____
Name DOB

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include Dr. Montgomery's time required for the reading of records, consultations with other psychologists and professionals, scoring, interpreting the results, and any other activities to support these services.

I understand that the fee for this (these) service(s) will be payable in two parts: a deposit of 50% payable before the start of this (these) services, and a second payment of the balance due on the completion and delivery of any report. Though my health insurance may repay me for some of these fees, I understand that I am fully responsible for payment for any services not covered by my insurance or for services provided when we do not participate as a provider under your insurance plan. If information is requested from third parties Dr. Montgomery cannot be responsible for their responses, or lack of response, to requests to participate in the evaluation process. Dr. Montgomery will, at his sole discretion, determine if additional attempts will be made to solicit input from any third party(ies).

I understand that this evaluation is to be done for the purpose(s) of:

1. Diagnostic determination
2. Recommendations for educational, social, emotional, language, and behavioral planning

I also understand Dr. Montgomery agrees to the following:

1. The procedures for selecting, giving, and scoring the tests, interpreting and storing the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of HIPAA/FERPA and the State Board of Examiners of Psychologists and are governed by the laws of the State of Georgia.
2. Tests will be chosen that are suitable for the purposes described above. (In psychological terms, their reliability and validity for these purposes and population have been established.) These tests will be given and scored according to the instructions in the tests' manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
3. Tests and test results will be kept confidential and in a safe place.

I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

Signature of client (or parent/guardian) Date

I, Robert W. Montgomery, Ph.D., have discussed the issues above with the parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Robert W. Montgomery, Ph.D., BCBA-D Date

_ Copy accepted by client _ Copy kept by psychologist
This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Confidential

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information which you think may be helpful in understanding your child. Reinforcement Unlimited, LLC will hold information provided by you is strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law. Please use the backs of the pages for additional information.

PLEASE PRINT

Name of Person Completing this form: _____

Legal Name of Child/Adolescent: _____

Nickname or name child routinely goes by: _____

Child's Date of Birth: _____ Age: _____

Home Address: _____
Street

_____ City _____ County _____ State _____ Zip _____

Home Telephone Number: ____-____-____ Work Phone(s) Mother: ____-____-____

Father: ____-____-____

Cellular Phone(s) Mother: ____-____-____

Father: ____-____-____ Preferred Email: _____

School Name: _____ System: _____ Grade: _____

School Telephone Number: _____ Contact Person: _____

Current Teacher(s): _____

Who referred you to our office? _____

Please describe the problems your child is now having, and what type of services you are seeking from us for these problems. Please use the back of this page for additional space.

INDICATE PARENTS/GUARDIANS LIVING IN THE HOME:

Marital Status: Married Remarried Divorced Separated Widowed Single Cohabitants

- If divorced, who has physical custody? _____ Is it full or joint? _____
- Who has legal custody? _____ Is it full or joint? _____
- If divorced, please provide a copy of the custody agreement.

Mother's Name _____

Date of Birth: _____ Age: _____

Occupation: _____

Employer: _____

Education Completed _____ Health: _____ Excellent _____ Good _____ Fair _____ Poor

Father's Name _____

Date of Birth: _____ Age: _____

Occupation: _____

Employer: _____

Education Completed _____ Health: _____ Excellent _____ Good _____ Fair _____ Poor

Does either parent's job require him/her to be away from home long hours or extended periods?

If married, how long have you been married? _____

If divorced, how long have the biological parents been divorced? _____

Has either parent been married before or since? Mother: _____ Father: _____

Please list the name(s) of the stepparents: _____

If yes, provide dates of previous marriage(s), names, and ages of children from these marriages:

Mother: _____ Children & Ages: _____

Father: _____ Children & Ages: _____

Is there a birth parent living outside the home: (circle one) MOTHER FATHER

Name: _____ Where do they live? _____

If birth parent(s) do not live in the child's home, how much contact does the child have with the parent not having custody, with stepsiblings, etc.?

Siblings:

	Name	Age	Relationship	Living in Home?	School	Grade
1.	_____	_____	_____	Y/N	_____	_____
2.	_____	_____	_____	Y/N	_____	_____
3.	_____	_____	_____	Y/N	_____	_____
4.	_____	_____	_____	Y/N	_____	_____

- Please list additional Siblings in the above format on the back of this page.

Please indicate any special needs of concerns regarding the other children living in your home:

Please indicate any concerns you have regarding the child for whom you are seeking services and these siblings relationship(s):

Others: List any other people who currently, or in the child's lifetime, have lived in your home.

Name	Age	Relationship to Child	Years Living in Home
1. _____	_____	_____	From_____ To_____
2. _____	_____	_____	From_____ To_____
3. _____	_____	_____	From_____ To_____
4. _____	_____	_____	From_____ To_____
5. _____	_____	_____	From_____ To_____

Are there any other people who have a significant role on how this child is raised? _____

PSYCHOLOGICAL HISTORY:

Is there a history in your immediate or in the mother's or father's extended family, of the following, and if so who?

Yes	No		Who
___	___	Autism Spectrum Disorders	_____
___	___	Learning Problem/Disabilities	_____
___	___	ADHD – ADD- Attention Problems	_____
___	___	Depression & Manic-Depression	_____
___	___	Behavior Problems in School	_____
___	___	Anxiety Disorders (OCD, Phobias, etc.)	_____
___	___	Mental Retardation	_____
___	___	Psychosis/Schizophrenia	_____
___	___	Substance Abuse/Dependence	_____
___	___	Other Mental Health Concern (Please List)	_____

Has the child you are seeking services for been evaluated in the past? Yes/No

If Yes, please list the following information on the previous evaluation(s):

	Who	Type	When	Copy Available
1.	_____	_____	_____	Y/N
2.	_____	_____	_____	Y/N
3.	_____	_____	_____	Y/N
4.	_____	_____	_____	Y/N

(If more evaluations need to be listed please use the space on the back of this page. □)

If yes, what were their general findings and recommendations? _____

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child: _____

PRE-NATAL AND DELIVERY HISTORY:

- Did the birth mother receive regular pre-natal care? Y/N
- Were there any complications with the Pregnancy? Y/N

If Yes, please provide details: _____

If Yes, please provide treatment details: _____

- Was birth at Full Term? Y/N

If No, please provide details: _____

- Type of Delivery: Spontaneous/Induced Vaginal/C-Section

- Complications? Y/N

If Yes, please provide details: _____

- Birth Weight: ____lbs ____oz Apgar Scores: _____

- Concerns at Birth? Y/N

If Yes, please provide details – including any treatments given (Additional space on back if needed):

Is there any additional pre-natal or birth information that might be of assistance to us? _____

Has your child ever had a fever above **104°**? Yes No

If yes, Please explain: _____

Has your child ever had a seizure of unexplained period of unconsciousness? Yes No

If yes, Please explain: _____

Has your child ever had a head trauma or blow to the head that cause unconsciousness or required a medical review?

If yes, Please explain: _____

(Please use the back of the form as necessary to complete your responses.)

DEVELOPMENTAL HISTORY:

1. Please indicate the age at which your child did the following:

- Rolled Over consistently _____
- Sat up unsupported _____
- Stood _____
- Crawled _____
- Walked Unassisted _____
- Said 1st Word Intelligible to strangers _____
- Said two-three word phrases _____
- Used Sentences regularly _____
- Toilet trained during the day _____
- Dry through the night (6+ months) _____
- Dressed Self _____

2. Please indicate if your child is experiencing any of the following:

- Problems with eating _____
- Isolated socially from peers _____
- Problems making friends _____
- Problems keeping friends _____
- Problems getting to sleep _____
- Problems controlling temper _____
- Trouble waking up _____
- Fatigue/tiredness during the day _____
- Nightmares _____
- Bed wetting _____
- Soiling _____
- Problems with authority _____
- Anxiety _____
- Unmotivated _____
- Stress from conflict between parents _____
- Legal situation (anyone in the family) _____
- History of abuse _____
- Alcohol/drug use/abuse _____
- School concentration difficulties _____
- Grades dropping or consistently low _____
- Sadness or Depression _____

3. List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had.

4. List any medications your child is currently taking or has taken for extended periods (give dates and dosage level, if possible): _____

5. Child's current height: _____ Ft. _____ Inches Weight: _____ Lbs.

6. With which hand does the child write? _____

7. Does the child have any vision problems? _____

Please list date of last vision test and who performed (pediatrician, optometrist, school)

8. Does the child have any hearing problems? _____

Please list date of last hearing test and who performed (pediatrician, audiologist, school)

9. Name of child's physician(s) _____

Practice Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Name of child's physician(s) _____

Practice Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

(Please list information on additional Physicians on the back of the page)

EDUCATIONAL HISTORY:

1. List in chronological order all schools your child has attended:

Name	System	Year(s)	Grade	Special Ed?
•				
•				
•				
•				
•				

2. Name(s) of current teacher(s) _____

3. Does your child's teacher have concerns about him/her (list) _____

4. What is your child's favorite subject/class? _____

5. What is your child's least preferred subject/class? _____

6. Has your child ever repeated a grade? Y/N If yes, what grade(s)?: _____

7. If your child has been in Special Education, did they have a:

504 Plan

I.E.P.

Psychological Evaluation

Speech Evaluation

Behavior Intervention Plan

Occupational Therapy Evaluation

Physical Therapy Evaluation

Adaptive Technology Evaluation

Other(s): _____

8. If your child has been in Special Education, how were they served?

Consultation

Resource Classroom

Collaborative Education

Team Taught Classes

Pull-Out

Self-Contained Classroom

Special Program

Psychoeducational Center

9. Child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

_____ Football	_____ Karate	_____ Dance (type) _____
_____ Baseball	_____ Piano	_____ Music (type) _____
_____ Cheerleading	_____ Scouts	_____ Gymnastics (type) _____
_____ Basketball	_____ Soccer	_____ Other(s): _____

10. List any special abilities, skills, strengths your child has: _____

LEGAL HISTORY

Have you ever filed or been involved in any litigation? Please explain: _____

DISCIPLINE INFORMATION

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed:

Intervention	Very Unlikely					Very Likely					Effectiveness
Let situation go	1	2	3	4	5						_____
Take away a privilege (ex., no TV)	1	2	3	4	5						_____
Assign an additional chore	1	2	3	4	5						_____
Take away something material	1	2	3	4	5						_____
Send to room	1	2	3	4	5						_____
Physical punishment	1	2	3	4	5						_____
Reason with child	1	2	3	4	5						_____
Ground child	1	2	3	4	5						_____
Yell at child	1	2	3	4	5						_____
Send to time out	1	2	3	4	5						_____
List anything else you may do:											_____
_____	1	2	3	4	5						_____
_____	1	2	3	4	5						_____
_____	1	2	3	4	5						_____

Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Please circle the LEAST effective.

Please rate what percentage of discipline is handled by each of the following:

Father: _____% Mother: _____% Other: _____% (Please specify): _____

GENERAL INFORMATION

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

	<u>Like Child to do More Often</u>	<u>Like Child to do Less Often</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES:

I hereby voluntarily apply for and consent to behavioral and/or psychological services by Robert W. Montgomery, Ph.D., BCBA-D and/or the staff of Reinforcement Unlimited, LLC. This consent applies to myself, ward, or patient named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent. I understand that the potential benefits of undergoing these services may include obtaining a professional opinion, reduction of my symptoms, and an increased understanding of myself, my family, and/or my child. I understand that potential risks may include predictive validity of assessments (when applicable), possible disagreement with the opinions offered to me, and possible emotional distress when addressing my situation. I understand that alternative procedures include services provided by another professional. I understand that I may ask for a referral to another professional if I am not satisfied with the progress of my treatment. I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions – some of which are listed below: (1) where abuse or harmful neglect or children, the elderly, or disabled or incompetent individual is known or reasonably suspected; (2) where the validity of a will of a former patient is contested; (3) where such information is necessary for the professional to defend against a malpractice action brought by the client; (4) where such information is necessary for the professional/corporation to pursue payment for services rendered; (5) where an immediate threat of physical violence against a readily identifiable victim is disclosed to the professional; (7) where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue; (8) pursuant to a Court order, open DCFS investigation, National Security Investigation or otherwise allowed or compelled under the law, and (9) where the client is examined pursuant to a court order. I hold Robert W. Montgomery, Ph.D., BCBA-D and the staff of Reinforcement Unlimited, LLC harmless for releasing information under the above conditions.

Signature

Date

Printed Name

Name of Patient

Service Agreement and Consent Form

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us.

SERVICES OFFERED

We will provide services specifically designed to help you (and/or your minor child), or otherwise provide you with referrals to other professionals. Our clinical and behavioral services consist primarily of individual assessments (psychological and behavioral evaluations), training, in-home and in-school consultation and observations, long-term service provision to youth in the autism spectrum, and short-term consultations with individuals, parents, educators, and other related professionals.

APPOINTMENTS

Except for rare emergencies, we will see you (or your child) at the time scheduled. We understand that circumstances (such as an illness or family emergency) may arise which necessitate the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you speak to us personally and give us as much notice as possible to cancel or reschedule. This will allow us to offer your time to another person. You may be charged the standard hourly rate (see below) for appointments unkept or cancelled with less than 48 hours advance notice. Please note that most insurance companies will not reimburse you for missed appointments and you remain responsible for these charges.

PREPARATION FOR TESTING

It is important that individuals be able to perform at their best during testing sessions. Please let us know before you arrive (and as soon as possible) if the individual to be tested is not feeling well, or is taking any prescribed or over-the-counter medications that we have not been told of in advance. In such cases, the testing session may need to be rescheduled. Individuals to be tested should be well rested and should bring snacks for breaks during the testing session. Because of the variety of dietary restrictions we do not offer any food or snacks in our clinic. Parents should plan to remain in the office during testing sessions with their minor children unless other (previous) arrangements have been specifically discussed with us and agreed to by us.

CONFIDENTIALITY, RECORDS, AND RELEASE OF INFORMATION

Psychological services are best provided in an atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals, or under other conditions and as mandated by Georgia and Federal law and our professional codes of conduct/ethics. These exceptions are discussed below.

TO PROTECT THE CLIENT OR OTHERS FROM HARM

If we have reason to suspect that a minor, elderly, or disabled person is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions which could include notifying the police, an intended victim, a minor's parents, or others who could provide protection, or seeking appropriate hospitalization.

PROFESSIONAL CONSULTATIONS

Psychologists and Behavior Analysts routinely consult about cases with other professionals. In so doing, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them. Unless you object, we do not typically tell clients about these consultations; however, these consultations will be so noted in your Private Health Information. If you want us to talk with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared.

RECORDS

We will review all testing results during our feedback session, and offer you opportunities to review raw testing data with us. You will receive a written report that summarizes our findings. This report will include a summary and interpretation of all individual testing, as well as impressions from individual observations and consultations conducted as a part of a comprehensive individual evaluation. Upon your request, we are happy to provide you with a written summary of our impressions from other meetings, consultations, or observations as well. We will forward copies of any reports or written summaries to others only with specific, written consent from you. Because of the proprietary nature of testing materials, we will release raw testing data only to other appropriately credentialed professionals (except as otherwise required by law).

LEGAL PROCEEDINGS

If you are involved in a court proceeding and a request is made for information concerning our professional services, such information is protected by the psychologist-patient privilege law for Dr. Robert Montgomery but there is limited protection for information conveyed to others employed by or consulting to Reinforcement Unlimited, LLC under the law. Dr. Montgomery cannot provide any information without your written authorization, open DCFS investigation, National Security investigation, or a court order. However, we may be forced to reveal information. In that case, we will reveal only the minimally acceptable amount of information. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information. Also, if a client files a complaint or lawsuit against anyone affiliated with Reinforcement Unlimited, LLC, we may disclose any and all relevant information regarding that client we deem necessary in order to defend ourselves.

PAYMENT FOR SERVICES

If you have a question or objection to fees assessed objections or inquiries must be made within 90 days of receipt of the relevant invoice in order to allow review and consideration. Inquiries regarding invoices over 90 days old will be deemed untimely and payment will be expected for services. If necessary, we may seek assistance from an outside party in order to collect payment for services. In such cases, any disclosures are limited to the minimum that is necessary to achieve the purpose. As you might suspect, the laws and professional standards governing these issues are quite complex, and it is important that we discuss any questions or concerns that you (or your minor child) may have at our first meeting, and as they may arise in the course of our work together. If any of these types of situations arise, we will make every effort to fully discuss it with you before taking any action, and we will limit my disclosure to

what is necessary. We are not attorneys, however, and you may wish to obtain formal legal consultation if you need specific advice.

WORK WITH MINOR CHILDREN

If a client is under eighteen (18) years of age, the law may provide parents with the right to examine the minor child's records. Privacy, however, is often crucial to successful progress in treatment and valid evaluation results. If, in the course of an evaluation or consultation, a minor child reveals to us information that he or she does not want shared with his or her parents or guardian, we usually do not reveal such information unless we believe that there is a high risk that the minor will seriously harm him/herself or others, and in which case we will notify him or her of my intent to notify his/her parents or legal guardian(s).

FEES

Our hourly fee is \$175 per 50-minute hour for consultations, meetings, and therapy for Dr. Robert Montgomery. Our hourly fee is \$150 per 50-minute hour for consultations, meetings, and therapy for Dr. Christine Montgomery. Our hourly fee is \$125 per 50-minute hour for consultations, meetings, and therapy for our masters-level BCBA staff and consultants. We charge this same fee on a pro-rated basis for telephone calls longer than five (5) minutes. Our hourly fee is \$90 per 50-minute hour for consultations, meetings, and therapy for our masters-level staff and consultants. We charge this same fee on a prorated basis for telephone calls longer than five (5) minutes, and for travel time for out-of-office meetings for our masters-level and service provider staff. Travel and daily rates for Drs. Montgomery are arranged via individual contract agreement. Payment in full is due at the end of each appointment, except for testing, or within 15 days of receipt of monthly service invoices. For individual testing, however, we charge a flat fee for evaluations: \$1900 for a standard psychological diagnostic evaluation, and \$2350 for evaluations requiring neuropsychological assessment. An extensive amount of time is committed and required to provide this kind of service; therefore, we ask that 50% of this fee be paid as a deposit at the time of the appointment making arrangements for the testing sessions: the balance is due at the time of our meeting to review the report and address any questions. This fee/evaluation typically includes a review of records that you provide to us, an initial one-hour interview with the referral source (usually a parent or guardian in the case of a minor child), limited consultations with other professionals working with you or your child, direct testing, scoring, preparation of one comprehensive written report, and a one-hour feedback session and a follow-up phone call (of less than 30 minutes). Additional services such as any other consultative or therapeutic sessions, follow-up consultations with you or other parties (such as teachers, physicians, or other allied professionals), school observations (that may or may not be part of a more comprehensive evaluation), or preparation of any additional reports, will be charged at the appropriate hourly rate (including travel and preparation time as necessary). We accept payment in the form of cash, checks, American Express, Discover, MasterCard, or Visa. If, during the initial interview, the decision is made not to proceed with an evaluation, only the fee for the interview will be charged. In the unlikely event that you fail to pay us for services rendered and your account is more than 30 days past due, we may enlist the services of other persons or agencies to collect past-due amounts, and you will also be charged for any expenses so incurred and by signing this agreement agree to those fees. Additionally, confidentiality is waived in cases in which outside agencies are required to pursue payment of unpaid debts.

HEALTH CARE INSURANCE

If we do not file your insurance claims at this time, we will provide you with statements that you may submit to your insurance carrier or complete any forms as required by your insurance carrier in order to obtain reimbursement for out-of-network providers. In order to assist you with obtaining reimbursement for our services, your insurance carrier may require that we provide a clinical diagnosis, or additional clinical information such as treatment plans or summaries, or copies of your child's entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is

necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Although all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report or form that we submit upon your request. By signing this Agreement, you agree that we can provide requested information to your carrier if/when you choose to file a claim for any services that we have provided to you or your child. Also be advised that many insurance plans do not pay for psychological and behavioral testing or significantly limit the amount of coverage they provide for this kind of service, this is also true for testing and therapy services for Autism Spectrum Disorders (or other services judged to be primarily educational in nature). Public school systems, however, administer individual evaluations to school-age children at no cost to you (as governed by local/state educational agency regulations). Students enrolled in public universities in Georgia may be eligible for low-cost evaluations through the Regents Centers for Learning Disorders; contact your local public school or college/university Office of Disabilities Services, respectively, for additional information.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep clients' Protected Health Information in two sets of professional records. One set constitutes the Clinical Record. It includes information about reasons for seeking our professional services; the impact of any current or ongoing problems or concerns; assessment, consultative, or therapeutic goals; progress towards those goals, a medical, developmental, educational, and social history; treatment history; any treatment records that we receive from other providers; reports of any professional consultations; billing records; releases; and any reports that have been sent to anyone, including statements for your insurance carrier. Except in unusual circumstances that involve danger to yourself or others, or makes reference to another person (unless such other person is a health care provider) and we believe that access is reasonably likely to cause substantial harm to such other person, you or your legal representative may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers, or may contain information that is protected by federal copyright laws. For this reason, we recommend that you initially review them in Dr. Montgomery's presence, or have them forwarded to another mental health professional so that you can discuss the contents. In most situations, we are allowed to charge a fee for copying (and for certain other expenses) plus postage and this is regulated under Georgia Law. The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your records, you have a right of review (except for information provided to us confidentially by others) which we will discuss with you upon request. In addition, we also keep a set of Personal Notes for most clients to whom we provide even brief or consultative services. These notes are for my own use and are designed to assist us in providing you with the best treatment. While the contents of Personal Notes vary from client to client, they include references to conversations, psychological testing recording forms, our analysis of those conversations, and the effects of these conversations on my clients. They also may contain particularly sensitive information revealed to us that is not required to be included in the Clinical Record (and information supplied to us confidentially by others). These Personal Notes are kept separate from the Clinical Record. Personal Notes are not available to you and cannot be sent to anyone else, including insurance companies. Your signature below waives all rights, now and in the future, to accessing these records. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting

an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

CONTACTING US

Given our many professional commitments, we are often not immediately available by telephone. If you need to leave us a message, we will make every effort to return your call promptly (within 24-48 hours with the exception of holidays and weekends). If you are difficult to reach, please leave some times when you will be available. Because of the nature of the services we usually provide, **We do not provide on-call coverage 24 hours per day, 7 days per week.** In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room. Please be advised that due to issues of confidentiality Reinforcement Unlimited, and its staff, will not correspond about specific children or their services via email or other electronic communication method. If your inquiry is about a specific child's services please call the office at one of the numbers above.

CONSENT

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms, and that you have received the HIPAA notice form described above or have been offered a copy and declined. Consent by all parents/legal guardians (those with legal custody) is required.

Client or Child's name

Client or Child's signature

Parent/Guardian #1 name

Parent/Guardian #1 signature

Date

Parent/Guardian #2 name

Parent/Guardian #2 signature

Patient Name: _____ DOB: _____

PATIENT CONFIDENTIALITY CONTACT FORM

Patient confidentiality is a top priority at Reinforcement Unlimited, LLC. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.

In the event that I, _____, am unable to be reached, Reinforcement Unlimited, LLC may leave information with the following:

_____ Other Adult in Household (Name): _____

_____ On Home Answering Machine (#): _____

_____ On Cell Phone (#): _____

_____ I may be reached at my work number: _____

_____ May leave a message at work on my voicemail: _____

_____ Other (Please describe): _____

OPT OUT (Initials) _____ in the event that I am unable to be reached, Reinforcement Unlimited, LLC **MAY NOT** leave information with anyone but myself. **I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff at Reinforcement Unlimited, LLC.**

Patient's Signature: _____ **Date:** _____

Parents Signature: _____ **Date:** _____



Reinforcement Unlimited, LLC

P. O. Box 1572
Woodstock, GA 30188
(770) 591-9552
ASAP@Behavior-Consultant.com

107 Weatherstone Drive #530
Woodstock, GA 30188
Fax (800) 218-8249
www.Reinforcementunlimited.com

Medicaid Coverage Statement

Thank you for your inquiry regarding Medicaid coverage for services from Reinforcement Unlimited, LLC and/or Dr. Robert Montgomery. We regret that at this time we cannot accept Medicaid as coverage for our services in this matter. However, we can offer to provide services to you as a private pay patient. This means that we will provide treatment/evaluation services but cannot accept Medicaid in part or whole as payment for any services rendered to you or your child. If you are insured by private insurance and we have been allowed to be a provider on their panel we will make every effort to submit bills to that insurer and accept assignment of benefits with appropriate approval from you. However, you remain responsible for any amount not covered by your insurer and the remaining uncovered fees will not be subject to submission to Medicaid. If your insurance provider has not allowed us to participate as a provider you remain responsible for the entire amount billed. We will provide documentation for you to submit for reimbursement for our services as an "out-of-network" provider but can make no representations as to the amount of reimbursement, if any, you will receive from your insurance company for our services.

You are under no obligation to select Reinforcement Unlimited, LLC or Dr. Robert Montgomery as your service provider. To the best of our knowledge you can contact the following agencies for similar services and are likely to be covered by Medicaid:

Emory Autism Center
1551 Shoup Court
Atlanta, Georgia 30322
(404) 727-8350

The Marcus Institute
1920 Briarcliff Road
Atlanta, GA 30329
(404) 419-4000

If you currently are covered by a Georgia Medicaid CMO you can contact them for alternative service providers. You may contact the managed care organizations at the following numbers:

Amerigroup 800-600-4441
Peach State 800-704-1484
WellCare 866-231-1821

My signature below indicates my understanding that services by Reinforcement Unlimited, LLC and/or Dr. Robert Montgomery are not covered in any way by Medicaid and that there are no alternative services through Reinforcement Unlimited, LLC and/or Dr. Robert Montgomery available which are covered by Medicaid in this matter.

Signature

Date

Printed Name



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PAYMENT POLICY

Our office strives to offer the highest quality of care. Never will your care be contingent on your insurance coverage. "Insurance is a method of payment, not a method of treatment." Considerable care has been taken to determine our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. Our fees are comparable to those of other highly qualified specialists. Whether you have purchased insurance on your own or your employer has provided it to you, you are fortunate to have it and we will go the extra mile to help you maximize your benefits provided by your specific plan. As a courtesy to you, we will file with those plans to which we have been admitted as a provider and when requested and we have not been admitted as a provider will complete the standard CMS1500 claim form for you to seek reimbursement through your insurer. When a service is covered, your insurance company usually only pays a percentage of the fee, and this varies from carrier to carrier and plan to plan. Your insurance is not designed to pay the entire cost of treatment, but it is intended to help cover a certain portion of the cost. A better term for insurance may be "rebate".

Please remember, however, the financial obligation for our services is between you and this office, and is NOT between this office and the insurance company.

Payment to our office is not contingent, nor dependent upon your insurance company. All account balances must be satisfied within 60 days of the date services were billed, after that time a rebilling fee of \$10.00 may be charged to your account. A \$45.00 fee will be charged for any returned check, and alternative means for meeting the obligation will have to be arranged with us. If you have any questions regarding our financial policy, please do not hesitate to discuss them with us. For your convenience, we accept MasterCard, Visa, American Express, Discover, Cash, and Checks.

I understand and agree that I am responsible for the payment of all charges incurred regardless of any insurance coverage or other plans available to me and my dependents. Additionally, I understand and agree to pay any and all collections costs and/or attorney's fees if any delinquent balance is placed with an agency or attorney for collection, suit, or legal action. I also acknowledge that confidentiality is waived in matters involving collections and the sharing of information sufficient to pursue recovery of debts owed.

Signature

Date

Printed Name

Soc. Security#/DL#



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Request/Authorization to Release Confidential Medical & Mental Health Records and Information

Source of information:

Person or facility: _____
Address: _____ FAX: _____
_____ Phone: _____

A. Identifying information

Name: _____
Address: _____
Phone: _____ Birthdate: _____
Parent/guardian (if applicable): _____
Address and phone of parent/guardian: _____

B. I hereby authorize the source named above to send, as promptly as possible, the records listed below marked below to Reinforcement Unlimited, LLC at the address listed above. (The items not to be released have a line drawn through them.)

- Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness:
 - Date(s) of inpatient admission: _____ Date(s) of discharge: _____
 - Start of outpatient treatment: _____ End of treatment: _____ Clinic/patient number: _____
 - Other identifying information about the service(s) rendered: _____
- Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the patient.
- Psychiatric evaluations, reports, or treatment notes and summaries.
- Treatment plans, recovery plans, aftercare plans.
- Admission and discharge summaries.
- Social histories, assessments with diagnoses, prognoses, recommendations, and all similar documents.
- Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.
- Workshop reports and other vocational evaluations and reports.
- Billing records.
- Academic or educational records.
- Report of teachers'/staff observations.
- Achievement and other tests' results.
- A letter containing dates of treatment(s) and a summary of progress.
- ~~Drug and Alcohol information contained in these records will be released~~
- ~~HIV-related information and contained in these records will be released~~
- Other: _____

(cont.)

C. I further authorize the source named above to speak by telephone with staff of Reinforcement Unlimited, LLC (identified in the letterhead) about the reasons for my/the patient's referral, any relevant history or diagnoses, and other similar information that can assist with my/the patient's receiving treatment or being evaluated or referred elsewhere.

D. I understand that no services will be denied solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan. The information disclosed may be used in connection with my/the patient's treatment.

E. This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release mental health information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93- 282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

F. In consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom.

G. This request/authorization is valid during the pendency of any claim or demand made by or on behalf of me/the patient, and arising out of an accident, injury, or occurrence to me/the patient. I understand that I may void this request/ authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire in 365 days from the date I signed it.

H. I agree that a photocopy, electronic, or faxed copy of this form is acceptable in lieu of the original form.

I. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

J. Signatures

Signature Printed name Date

Signature of parent/
guardian/representative Printed name Relationship Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

Signature of witness Printed name Date