

Gentry Pediatric Behavioral Services, PLLC Evaluation and Treatment Process

IMPORTANT INSTRUCTIONS

1. Download, print, read and fill out ALL of the forms including:
 - Reason for Referral
 - Consent
 - Developmental History
 - Authorization to Release Information –
 - Informed Consent (for therapy clients only)
2. ***Fill out the Authorization to Release/Exchange information form for your child's school district if he/she is being evaluated as an Independent Educational Evaluation (IEE)*
3. Fax or Mail ALL forms back to : Gentry PBS (Intake)
 - 7600 N. 16th Street, Suite 218
 - Phoenix, AZ 85020
 - Fax- (602) 314-4175
4. Upon receiving these forms, you will receive a phone call and/or e-mail to schedule an intake/assessment appointment with our team at Gentry PBS.

During the intake portion of our meeting, we will go over all of the forms and collect important information from you regarding your child. Therefore, it is important that you bring copies of important documents, such as:

- A picture of your child
- Current IEP's
- Past Evaluation Reports
- Current/Past Behavior Plans

Thank you, if you have any questions please do not hesitate to call me at 602-312-2911.
Joseph "Dr. Joe" Gentry, Ph.D., BCBA-D

INITIAL INTAKE QUESTIONNAIRE

Please print clearly and complete all items. Write N/A for items that do not apply to you. Note any item(s) that you are unsure how to answer. The psychologist will review the form with you and answer any questions during the initial interview.

First and last name of person completing form: _____

Relationship to client: _____ Date of completion: _____

REASON FOR REFERRAL

How did you hear about Gentry PBS? _____

What services are you interested in receiving from Gentry PBS?

- | | |
|---|--|
| <input type="checkbox"/> Independent Educational Evaluation | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Private Educational Evaluation | <input type="checkbox"/> Parent Training |
| <input type="checkbox"/> Diagnostic Evaluation | <input type="checkbox"/> Behavioral Consultation |
| <input type="checkbox"/> Functional Behavioral Assessment | <input type="checkbox"/> Unsure |

Please describe why you want your child to be seen at this time? _____

What are your goals for evaluation/treatment/consultation?

1. _____
2. _____
3. _____

CLIENT/CHILD INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Nickname: _____ SSN: _____ Gender: Male Female

Ethnicity: _____ Primary Language: _____ Language spoken at home: _____

Date of Birth: _____ Place of birth: _____
month / day / year city / state

Address: _____
street / city / state / zip code

County of Residence: _____ Home Phone: (_____) _____

E-mail: _____ Cell Phone: (_____) _____

Who does the client live with?

Both parents Mother Father Other (specify): _____

Physician: _____ Phone: (_____) _____

Address: _____
street / city / state / zip code

PARENT/GUARDIAN INFORMATION

Mother/Guardian: Birth mother Adoptive Stepmother Guardian Other

Mother's name: _____ Date of Birth: _____

check here if contact information is the same as client's, and if so, skip directly to e-mail

Address: _____

street / city / state / zip code

County of Residence: _____ Home Phone: (_____) _____

E-mail: _____ Cell Phone: (_____) _____

Occupation (if applicable): _____ Work Phone: (_____) _____

Highest level of education completed: _____

Father/Guardian: Birth father Adoptive Stepfather Guardian Other

Father's name: _____ Date of Birth: _____

check here if contact information is the same as client's, and if so, skip directly to e-mail

Address: _____

street / city / state / zip code

County of Residence: _____ Home Phone: (_____) _____

E-mail: _____ Cell Phone: (_____) _____

Occupation (if applicable): _____ Work Phone: (_____) _____

Highest level of education completed: _____

Parents' Marital status:

Married Divorced Separated Widowed Never married Unknown

Please indicate date married/divorced/separated/widowed: _____

If parents are separated/divorced, who has custody: _____

(please attach legal documentation)

Siblings: List all full, half, stepbrothers and sisters of child, living or deceased, in birth order.

Name	Sex	Age	Relationship to Child/Client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other members living in the household: Yes No

If yes, list names and relationship to the child: _____

FAMILY HISTORY

Has anyone in your immediate family experienced any of the following in the last two years (please explain):

Moved _____ Divorce _____

Marriage _____ Separation _____

Serious illness _____ Accident _____

Death _____ Arrests _____

Any other significant events: _____

Describe any major medical or mental illness(es) in family members: _____

DEVELOPMENTAL HISTORY

Did mother use any of the following during pregnancy? Tobacco: Yes No
Alcohol: Yes No
Drugs: Yes No

Describe any difficulties or complications during pregnancy: _____

Length of pregnancy: _____ Birth weight: _____

Type of birth: Vaginal Caesarian Section

Please state the age at which your child did the following. If you do not remember the exact age, give the approximate age.

Motor	Language
Sat alone: _____	Age of first words: _____
Stood alone: _____	Combined 2 words: _____
Walked alone: _____	Used 3-4 word sentences: _____

Please indicate any difficulties your child has had with the following:

Toileting:	<input type="radio"/> In the past	<input type="radio"/> Currently	<input type="radio"/> Never
Eating:	<input type="radio"/> In the past	<input type="radio"/> Currently	<input type="radio"/> Never
Sleeping:	<input type="radio"/> In the past	<input type="radio"/> Currently	<input type="radio"/> Never

When did you start to worry about your child's development? _____

Has your child been diagnosed with a special need(s)? Yes No

If yes, indicate: _____

Is he or she receiving any special services and by whom? _____

MEDICAL HISTORY

(If you need more room, feel free to add your own page)

Serious illnesses or hospitalizations? Yes No If yes, explain: _____

Serious head injuries or accidents? Yes No If yes, explain: _____

Vision Problems or glasses? Yes No If yes, explain: _____

Hearing Problems or hearing aides? Yes No If yes, explain: _____

Has your child been diagnosed with a physical condition or allergies? Yes No If yes, explain: _____

Has the child ever had treatment for this? Yes No

If yes, when and where? _____

Has your child been diagnosed with a psychological or behavioral disorder? Yes No If yes, explain: _____

Has the child/client ever had treatment for this? Yes No

If yes, when and where? _____

Has your child had a history of any trauma, abuse, or neglect? Yes No If yes, explain: _____

List any medication or supplements child/client is receiving:

Medication	Dosage	Time(s) given
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any odd eating habits: _____

Does he or she have a special diet or food allergies? _____

Previous Psychological/Psychiatric Evaluations Yes No

If yes, list Date, Evaluator, Location, and Reason for Testing (e.g. March 2008, Dr. Smith, Good Clinic, diagnostic evaluation):

SOCIAL/BEHAVIORAL HISTORY

Please select any behavioral characteristics that apply to your child:

- | | |
|---|---|
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Sad or depressed |
| <input type="checkbox"/> Contact with police | <input type="checkbox"/> Cries a lot |
| <input type="checkbox"/> Noncompliant | <input type="checkbox"/> Happy |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Distractible | <input type="checkbox"/> Worries a lot |
| <input type="checkbox"/> Forgetful | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Perfectionist |
| <input type="checkbox"/> Overly active | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Friendly |

Any other behavioral problems: _____

Does your child play well and socialize with other children? Yes No

Explain: _____

Does he or she have friends? Yes No

Favorite toys or activities: _____

Any preoccupations/rituals/obsessions? _____

Is your child unusually frightened by: animals rough children loud noises the dark

Does your child belong to any social groups, clubs, or sports teams? Yes No

If yes, please indicate: _____

STRENGTHS OF CHILD/CLIENT AND FAMILY

What are the child's strengths? _____

What are your family's strengths? _____

EDUCATIONAL HISTORY

School the child currently attends: Preschool Name: _____
 Public School Name: _____
 Private School Name: _____

Grade: _____

Address: _____
street / city / state / zip code

School phone number: _____ School district: _____

Name of classroom teacher: _____ Teacher's email address: _____

List all schools attended, including preschool.

School	Type of Class	Grades	Dates attended (Indicate grades repeated)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does your child experience frequent absences from school? Yes No

If yes, please explain: _____

Has your child been retained? Yes No

If yes, please explain: _____

Ever suspended? Yes No

If yes, what grade(s)? _____ Why? _____

Has your child been tested at school recently? Yes No (If yes, please attach the report)

Has your child been identified as gifted? Yes No

Does your child receive special education services? Yes No

If yes, what is the eligibility category? _____

What services does your child receive at school? _____

Please tell us anything else you think would be helpful in understanding you or your child. Include any questions you may have.

**AUTHORIZATION TO RELEASE/EXCHANGE PROTECTED HEALTH INFORMATION
(PHI)**

Print Name of Client

Date of Birth: _____

Print Name of Parent/Guardian providing authorization (if applicable)

Home Phone: _____

Address: _____
Street City State Zip Code

I hereby authorize the Gentry Pediatric Behavioral Services (G-PBS) to release/exchange the following confidential health information (for the purpose of continuity of care), related to the client named above via fax, phone, e-mail, or in person. With this consent, I understand that this means that confidential documents may be sent over the internet and that the internet is not always completely safeguarded and Protected Health Information could possibly be obtained by unauthorized users. I understand that this consent may be withdrawn at any time by notifying Gentry PBS, in writing, at the following address: 7600 N. 16th St., Suite 218, Phoenix, AZ 85020.

Psychological Educational Medical Other _____

Release/Exchange to:

Agency/School District Name and/or Professional's Name and Title Phone Number

Address: _____
Street City State Zip Code

I hereby **authorize** the release and/or exchange, mutual use, and/or disclosure of the information indicated above, for
 do not authorize these specified purpose(s), between Gentry PBS and the agencies/professionals listed above.

This authorization expires:

on _____
Specify Date or Condition of Expiration

one year from the date signed

upon Gentry PBS's receipt of a written request to revoke authorization (at the address below)

Print Name of Adult Client or Parent/Guardian

Signature

Date Signed

INSURANCE INTAKE QUESTIONNAIRE

Gentry PBS is currently in-network with Blue Cross Blue Shield and Cigna Insurance (2014)

Patient's name: _____ Patient's DOB: _____

Name of policy holder: _____ Policy holder's DOB: _____

check box if the patient is the policy holder

Policy holder's address:

Policy holder's phone number: _____

Name of insurance carrier: _____

Provider services phone number: _____

Insurance billing address: _____

ID: _____ Group #: _____

Name of policy holder's employer (if applicable): _____

Group plan name: _____

Gentry PBS has permission to contact my insurance carrier named above and discuss my coverage and services provided.

Signature of patient (or legal guardian)

date

verbal consent was give over the phone _____

signature of office staff

Office Use only:

Dx code:

GENERAL CONSENT

I, _____, consent to
Print Name(s) of Parent(s)/Guardian(s)/Adult Client, providing authorization
participation in, or authorize _____ to participate in assessment*, evaluation,
Print Minor Client's Name
treatment, and/or other services deemed necessary or advisable by Gentry PBS staff for those seeking to participate in Gentry
PBS programs and/or services.

Email Communications

**I authorize the use of electronic mail for any and all correspondence with myself, including scheduling, information gathering, and for the delivery of reports and other official documents. I understand that this means that documents with protected health information may be sent over the Internet and that the Internet is not always completely safeguarded from unauthorized persons. I understand consent may be withdrawn at any time by notifying Gentry PBS, in writing, at the following address:
Gentry PBS, 7600 N. 16th St, #218, Phoenix, AZ 85020.

EMAIL CONSENT	Parent 1	Parent 2
	_____	_____
	Initial	Initial

Print Name of Parent/Guardian/Adult Client

Signature of Parent/Guardian/Adult Client

Date Signed _____

If Joint Custody, second parent has to sign as well below.

Print Name of Parent/Guardian/Adult Client

Signature of Parent/Guardian/Adult Client

Date Signed _____

* The **Intake Questionnaire**, included with this General Consent form, represents a portion of the routine assessment process.

Under the Americans with Disabilities Act, GENTRY PBS must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, GENTRY PBS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that GENTRY PBS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact: GENTRY PBS (602) 312-2911.

NOTICE OF PRIVACY PRACTICES

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.

Gentry PBS is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

Treatment

We may disclose your health care information to other health care professionals *within* our practice for the purpose of treatment, payment or healthcare operations. On occasion, it may be necessary to seek consultation regarding your condition from other health-care providers associated with Gentry Pediatric Behavioral Services.”

Payment

We may disclose your health information to your insurance provider for the purpose of payment of health care operations. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to the Gentry Pediatric Behavioral Services for the health care services rendered. If you pay for your health care services personally, we will as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.”

Workers Compensation

We may disclose your health information as necessary to comply with State Workers Compensation Laws.

Emergencies

We may discuss your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purpose related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Health Oversight Activities

We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities may include monitoring, audits, investigations, inspections, and licensure.

Deceased Persons

We may disclose your health information to coroner’s medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research Purposes

In certain limited circumstances, we may disclose your PHI for research purposes. For example, a research project may involve the care and recovery of all enrolled persons who receive one medication for the same condition. All research projects are subject to a special approval process. We will obtain your written authorization if the researcher will use or disclose your behavioral health PHI.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposed or fundraising purposes, as described below:

(Example)

“As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“It is our practice to participate in charitable events to raise awareness, gifts, money, etc. During these time, we may send you a letter, post card, invitation or call your home to invite your to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of the Gentry Pediatric Behavioral Services sponsored fund-raising events.”

Change of Ownership

In the event that the Gentry Pediatric Behavioral Services is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, Gentry Pediatric Behavioral Services is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Gentry Pediatric Behavioral Services amend your protected health information. Please be advised, however, that Gentry Pediatric Behavioral Services is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of your denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Gentry Pediatric Behavioral Services.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Gentry Pediatric Behavioral Services reserves the right to amend this Notice of Privacy Practice at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Gentry Pediatric Behavioral Services is required by law to comply with this Notice.

Gentry Pediatric Behavioral Services is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if your want more information about your privacy rights, please contact the Billing Department at 602-312-2911.

Complaints

Complaints about your Privacy Rights or how Gentry Pediatric Behavioral Services has handled your health information should be directed to the Billing Department by calling this office at 602-312-2911.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509HHH Building
Washington, DC 20201

This page is intentionally left blank

I have read Gentry Pediatric Behavioral Services - Notice of Privacy Practices and understand my rights contained in the notice.

By way of my signature, I provide Gentry Pediatric Behavioral Services with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Print Name of Parent/Guardian/Client

Signature of Client/Parent/Guardian

Date Signed

Staff Name, Title/Credentials

Signature

Date Signed

Client Rights

A client has the following rights:

1. To be treated with dignity, respect, and consideration;
2. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;
3. To receive treatment that:
 - a. Supports and respects the client's individuality, choices, strengths, and abilities;
 - b. Supports the client's personal liberty and only restricts the client's personal liberty according to a court order; by the client's general consent; or as permitted in this Chapter; and
 - c. Is provided in the least restrictive environment that meets the client's treatment needs;
4. Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category of rights;
5. To submit grievances to agency staff members and complaints to outside entities and other individuals without constraint or retaliation;
6. To have grievances considered by a licensee in a fair, timely, and impartial manner;
7. To seek, speak to, and be assisted by legal counsel of the client's choice, at the client's expense;
8. To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights;
9. If enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, to receive assistance from human rights advocates provided by the Department or the Department's designee in understanding, protecting, or exercising the client's rights;
10. To have the client's information and records kept confidential and released only as permitted under R9-20-211(A)(3) and (B);
11. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without general consent, except:
 - a. For photographing for identification and administrative purposes, as provided by A.R.S. § 36-507(2);
 - b. For a client receiving treatment according to A.R.S. Title 36, Chapter 37;
 - c. For video recordings used for security purposes that are maintained only on a temporary basis; or
 - d. As provided in R9-20-602(A)(5);
12. To review, upon written request, the client's own record during the agency's hours of operation or at a time agreed upon by the clinical director, except as described in R9-20-211(A)(6);
13. To review the following at the agency or at the Department:
 - a. This Chapter;
 - b. The report of the most recent inspection of the premises conducted by the Department;
 - c. A plan of correction in effect as required by the Department;
 - d. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, the most recent report of inspection conducted by the nationally recognized accreditation agency; and
 - e. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, a plan of correction in effect as required by the nationally recognized accreditation agency;
14. To be informed of all fees that the client is required to pay and of the agency's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis situation;
15. To receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the proposed treatment;
16. To be offered or referred for the treatment specified in the client's treatment plan;
17. To receive a referral to another agency if the agency is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;
18. To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the

client's life or physical health, or is provided according to A.R.S. § 36-512;

19. To be free from:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Retaliation for submitting a complaint to the Department or another entity;
 - g. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent;
 - h. Treatment that involves the denial of:
 - i. Food,
 - ii. The opportunity to sleep, or
 - iii. The opportunity to use the toilet; and
 - iv. Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation;
20. To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan;
21. To control the client's own finances except as provided by A.R.S. § 36-507(5);
22. To participate or refuse to participate in religious activities;
23. To refuse to perform labor for an agency, except for housekeeping activities and activities to maintain health and personal hygiene;
24. To be compensated according to state and federal law for labor that primarily benefits the agency and that is not part of the client's treatment plan;
25. To participate or refuse to participate in research or experimental treatment;
26. To give informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment;
27. To refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings;
28. To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility.

Persons with developmental disabilities have the same rights as other US citizens including:

- To be treated with dignity and respect.
- To expect that the personnel caring for him/her will be current in skills and knowledge of their field of employment.
- To be served without regard to age, race, color, creed, sex, nationality, ancestry and disability.
- Protection from physical, psychological, verbal, or sexual abuse
- Access to public education
- Equal employment opportunities & compensation
- Placement evaluations
- Individual Support Program Plan (ISP)
- Right to ISP notes, participate in ISP & placement decisions
- Own, sell, lease property, marry, petition
- Presumption of Legal Competency
- Residential Program clients: right to humane, clean environment, communication, visits, personal property, live in least restrictive environment
- Right to withdraw from service
- Right to be informed of rights upon admission to service

Under the Americans with Disabilities Act, Gentry PBS must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, Gentry PBS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that Gentry PBS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact: Gentry PBS (602) 312-2911.

CLIENT FEES & REFUNDS

Client Fees

1. Parents/Guardians/Clients are responsible for coordinating/obtaining authorization for the funding of requested services from each applicable government funding agency (e.g., DDD, BH, Private Insurance, etc.). If/when a client receives Gentry PBS services before the funding is authorized (or in the event a funding agency removes said client from its active roster), the client or the person(s) legally responsible for the client will reimburse Gentry PBS for all services provided that were not reimbursed by the funding agency.
2. Parents/Guardians/Clients are responsible to provide Gentry PBS with updated insurance documentation every January and whenever insurance information changes.
3. A non-refundable deposit is required for some programs.
4. Program fees payable by clients via cash, check, or credit card; debit cards are not accepted unless the card doubles as a credit card.

Client Refunds

1. Individual refund requests should be made to CEO/Dr. Joseph Gentry. Requests are reviewed on a case-by-case basis.
2. Once approved, refunds are issued via Gentry PBS agency check, for payments made via cash or check or, for credit-card payments, refunds are credited to the client's credit card account.
3. The refund review process, including issuing approved refunds, is usually completed within 14 days of the request.

Signature

Date

FAMILY CONFIDENTIALITY AGREEMENT

The Gentry Pediatric Behavioral Services, PLLC is a psychological diagnosis and treatment organization that is in contact with many families each week. GENTRY PBS's mission is to provide treatment, support, and information to these families. Through the various programs offered by GENTRY PBS, families provide information of a personal and sensitive nature, under the assumption that such information will be kept confidential. ***The GENTRY PBS Staff have an ethical and legal duty to do this.***

As a family member participating in a GENTRY PBS program, it is imperative that **you also** understand these issues and agree to protect the privacy of other families who are served at GENTRY PBS.

By signing this document, I agree to:

- Respect the privacy of other families served by GENTRY PBS.
- Respect the confidentiality of sensitive materials, by not discussing personal information relating to other individuals and their families obtained at GENTRY PBS with anyone not directly involved in the GENTRY PBS program that my child/children are participating in.
- Respect the privacy of other families by keeping their names and other identifying information confidential.
- Not discuss any aspect of a child's development or family's personal information with people other than GENTRY PBS staff.
- Not discuss any aspect of current research studies or past study results with people other than GENTRY PBS research staff unless and until such research results are officially released or published by GENTRY PBS.
- Never use information available at GENTRY PBS for personal purposes.

Print Child/Client Name

Print Parent/Guardian Name

Parent/Guardian/Client Signature

Date

Signature of GENTRY PBS Staff

Date

Under the Americans with Disabilities Act, GENTRY PBS must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, GENTRY PBS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that GENTRY PBS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact: GENTRY PBS (602) 312-2911.

GRIEVANCE POLICY

Should an individual(s) wish to express dissatisfaction or file a complaint with regard to Gentry PBS services or personnel a grievance may be filed in the form of a phone call, letter, or personal contact. Gentry PBS will acknowledge the receipt of each grievance. This acknowledgement may be made verbally or in writing. If the grievance is filed verbally, acknowledgement is understood. If Gentry PBS chooses to acknowledge the grievance in writing, the acknowledgement will be made within five (5) working days.

Gentry PBS staff will attempt to resolve grievances within their purview, upon receipt. If the grievance is resolved to the complainant's satisfaction, at the time of the call or personal contact, the resolution is logged and the grievance is closed.

Grievances requiring the involvement of additional time and/or Gentry PBS staff are assigned and forwarded to the appropriate staff member for further review. GentryPBS ensures staff that make decisions on grievances are not involved in any previous level of review or decision-making. When a resolution is reached, the appropriate staff member contacts the complainant or the designated representative with the decision.

Date & Time: _____ Staff Member Receiving the Grievance: _____

Complainant: _____ Phone Number: _____
Address _____

City, State, Zip: _____

Name of Client(s) involved: _____

Complainant's relationship to client(s) or involvement in situation: _____

Name and title of any staff members involved: _____

Describe the situation (include events leading up to and after the event/situation): *Continue on the back of this form, if necessary.*

What does complainant want to happen?

If grievance was not resolved, grievance was referred to: _____

Staff Comments: _____

Resolution: _____

Resolved by: _____ Date: _____

Date complainant was notified: _____ Telephone Writing Other: _____

Comments: _____

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DISCHARGING A CLIENT INCLUDING AN INVOLUNTARY DISCHARGE

Gentry PBS discharges clients from time-limited programs upon completion (graduation) of the program. A client is discharged from an open-ended service (e.g., Multidisciplinary Team for Children with Autism and other Childhood Disorders/Disabilities) when treatment goals are satisfactorily met, according to the client's treatment plan, or when the client's behavioral health issues or treatment needs are not consistent with the behavioral health services that Gentry PBS is authorized or able to provide.

Gentry PBS shall ensure, at the time of discharge, that a client/family is provided a referral for treatment or ancillary services the client may need after discharge. Gentry PBS understands that most children/youth with autism spectrum disorders (ASD) and other childhood disabilities and disorders have complex medical, behavioral health, social, language, and educational needs. Programs are designed with this understanding in mind. However, on occasion, it may be necessary for Gentry PBS to involuntarily discharge a client who:

- has displayed uncontrolled aggressive outbursts,
- has displayed behavior that has been harmful to self or others,
- has displayed inappropriate sexual behaviors,
- has an active communicable disease (e.g., Tuberculosis),
- is not appropriate for, or unlikely to benefit from, the program due to age or other developmental issue,
- is excessively non-compliant with scheduled appointments
 - For Gentry PBS Programs, this includes families who are no-call/no-show for the second session in a program, or
 - For ongoing Gentry PBS services, families who have had 3 absences per quarter.

Gentry PBS shall ensure that a client/family is provided a written explanation for the involuntarily discharge, including a notification of the client/family's right to submit a grievance and a copy of Gentry PBS's grievance policy.

Acknowledgement of Receipt of Information

I/We, _____,
Print Name(s) of Parent(s)/Guardian(s)/Client, acknowledging receipt of information

acknowledge the receipt of the following:

- 1) **Notice of Privacy Practices**
- 2) **General Consent for Services**
- 3) **Gentry PBS's Fees & Refunds Policy**
- 4) **Family Confidentiality Agreement (if applicable)**
- 5) **Consent form(s) for audio, video, photographs (if applicable)**
- 6) An explanation of client rights
- 7) Gentry PBS's Grievance Policy

❖ Please **complete, sign, and date** items 1-5, in **bold**, and **return** them to Gentry PBS.

Print Name of Parent/Guardian/Client

Signature of Parent/Guardian

Date Signed

If Joint Custody, second parent has to sign as well below.

Print Name of Parent/Guardian/Client

Signature of Parent/Guardian

Date Signed

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