CLIENT REGISTRATION FORM

Client Name _____ Date of Birth _____
Last, First, Middle Initial

1. Caregiver/Guardian Name (1)

_____
Last, First, Middle Initial

Home Phone _____ Cell Phone_____ Email _____

2. Caregiver/Guardian Name (2)

_____
(if applicable) Last, First, Middle Initial

Home Phone _____ Cell Phone_____ Email _____

❑ I give permission for any medical records to be mailed to me at the address listed above.

☐ My child DOES NOT have known allergies nor has had an allergic reaction in the past. If there are any concerns or issues that I should become aware of that my child should not come in contact with, I agree to let Behavior Basics Incorporated know by updating their allergy list immediately.

☐ My child DOES have known allergies and I have supplied a full detailed list in the space provided below.

Allergy Alert: I am providing a detailed description of what my child is allergic to and the symptoms of a reaction. I understand that all medication must be in the original container and must be clearly labeled with my child's name. All medication must be hand delivered to a staff member. I understand that my child's medical needs will be posted at Behavior Basics, Incorporated, so that all staff and volunteers will be aware of those needs. I understand and agree that Behavior Basics Incorporated and its employees will not be held liable in so far as they administer medical care in conformance with the information provided on my child's medication consent form and food allergy action plan. Allergic reaction may occur is my child encounters or ingests the following: ***attach additional sheets as needed**

1. _____
2. _____
3. _____
4. _____

Pick up Authorization

I authorize Behavior Basics, Incorporated to release the above listed child into the care of any name listed below. I understand that any changes to this form must be communicated in writing. I further acknowledge that all authorized pick up person must be at least 18 years of age and will be asked to provide a photo identification.

Date: _____ Name: _____ Phone number: _____ Relationship to child: _____

Date: _____ Name: _____ Phone number: _____ Relationship to child: _____

Date: _____ Name: _____ Phone number: _____ Relationship to child: _____

Date: _____ Name: _____ Phone number: _____ Relationship to child: _____

Print Legal Guardian Name: _____ Date: _____

Signature: _____

CLIENT CONSENTS AND ACKNOWLEDGEMENTS

I certify that I am the parent/legal guardian of_____ .
Client's Name

_____*initials* **Consent for Treatment of a Minor**
I, as the parent or legal guardian of the client, do hereby give my consent and authorize treatment. Furthermore, the named individuals below may, if I am not present, in accordance with the consent communicated by the above individual to Clinicians pursuant to the delegation of my authority granted here, and consistent with the Clinician's professional judgement of my child's medical needs, authorize Clinicians to see, examine and evaluate and treat. This authorization will remain in effect until revoked by me in writing. I give permission to have evaluation and assessment services to be billed through my insurance company.

_____*initials* **Notice of Privacy Practices, HIPAA, Bill of Rights**
I acknowledge that I have received a copy of Behavior Basics Inc. Privacy Policy, HIPAA and bill of rights which describes the ways in which the proactive may use and disclose my health care information for its treatment and payment/health care operations and other described and permitted uses and disclosures. I understand Behavior Basics is unable to give out confidential client information to any party over the telephone or in person without your written authorization. I understand that I may contact the Operations Manager, if I have a question or complaint. To the extent permitted by the law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy.

_____*initials* **Financial Agreement**
I acknowledge that I have received a copy of Behavior Basics Inc. financial agreement and fully understand billing to insurance carriers, third parties, past due balances, forms of payments along with cancelled, missed, late appointment policy of Behavior Basics Inc. I understand that I will incur charges for appointments cancelled within 24 hours, or late arrivals to pick up from session.

_____*initials* **Liability Waiver**
I acknowledge that I have read the liability waiver carefully, understand its terms and conditions. I understand that use of the Facilities involves risks and dangers which include, without limitations, the potential of injury, disability, death, and other undefined harm or damage which may not be readily foreseeable (the "Risks") I further, acknowledge that I will be giving up substantial legal rights by signing it (including the rights of my spouse, child, heirs and next of kin, and any legal and personal representatives, executors, administrators, successors and assigns of same).

_____*initials I Do Consent* _____*initials I DO NOT consent* **Video/Photo Consent**
I authorize Behavior Basics Inc. assignees, licensees and legal representatives the irrevocable right to use my child's name, picture, portrait or photograph in all forms and media in all manners including composite or distorted representations for advertising, trade or any other lawful purposes and I waive any right to inspect or approve the finished product, including the written copy that may be created in connection therewith documentation, evaluation, and or training purposes.

_____*initials* **Emergency Transportation / Restrictive Procedures Consent /Emergency Medical**
I understand that in order to maintain client and staff safety and to provide effective behavioral treatment, it may be necessary to use management procedures that involve physical contact with my child. The philosophy of Behavior Basics, Incorporated is to use the least restrictive alternative necessary, while maintaining safety of all involved. I also understand that it may be necessary to employ emergency transportation and restrictive procedures as a temporary safety precaution. Behavior Basics employees will use verbal de-escalation, blocking and cushioning to protect persons and property during an aggressive or dangerous behavior. If these strategies do not deescalate the child, then a call to the mobile crisis team or 911 will be made. I further understand that should an event of any other medical emergency occur that cannot wait for caregiver return, Behavior Basics Inc. may contact 911 or have an ambulance transport child to nearest medical center for treatment.

Print Name_____Signature:_____Date_____

NOTICE of Video Recording in Behavior Basics Clinic Environment

Behavior Basics Incorporated, (BBI), has cameras installed throughout our buildings to maintain program integrity and to provide the highest level of service for children receiving ABA.

We use video footage and still images to enhance our staff's knowledge and provide ongoing, valuable training. Your child will be recorded during clinic therapy sessions for the purpose of ongoing supervision, education, and ongoing training of our therapists. The therapy session recordings will only be saved on our secure in-house server for ten days, pieces for training purposes may be snipped out and saved to be used in house to train BBI therapists.

In addition, some supplies / stimuli such as visual supports are best implemented with actual photos of our clients. These recordings and materials will not be shared outside the agency or by email, text, or other communication method but rather to help train and educate BBI staff on intervention procedures.

I acknowledge receipt of this notice.

Parent / Guardian Name (Print)_____

Parent / Guardian Signature_____ Date_____

LIABILITY WAIVER

Caregiver Name_____ Client's Name_____

Address_____Phone Number_____

RELEASE OF LIABILITY AND WAIVER OF LEGAL RIGHTS WHICH DEPRIVES YOU OF THE RIGHT TO SUE BEHAVIOR BASICS INCORPORATED ("Company"), ITS AFFILIATES, STAFF AND OTHER PARTIES. DO NOT SIGN THIS AGREEMENT UNLESS YOU HAVE READ IT IN ITS ENTIRETY. SEEK THE ADVICE OF LEGAL COUNSEL IF YOU ARE UNSURE OF ITS EFFECT.

In consideration of the Company permitting me and/or my child to use the kitchen, community room, class rooms, and other facilities located at 1887 SE Port St. Lucie Blvd., Port St. Lucie FL 34952 and/or 2401 W. Eau Gallie Blvd., Melbourne, FL 32935 (the "Facilities"), which permission may be revoked at any time with twenty-four hours advance written notice, I, for myself, my child and all those claiming through either of us, hereby make the following representations and agree to be bound by the terms of this Waiver and Release of Liability, Assumption of Risk and Indemnity Agreement (the "Agreement");

1. I hereby represent that (i) I am, and my child is, in good health and in proper physical condition to use the Facilities; and (ii) Neither I, nor my child, will be under the influence of alcohol or any illicit or prescription drugs which would in any way impair my ability, or my child's ability, to safely use the Facilities. I agree that it is my sole responsibility to determine whether I am, or my child is, sufficiently fit and healthy enough to use the Facilities.

2. I understand and acknowledge that there are physical rigors associated with using the Facilities and realize that the Facilities will be used by others simultaneously with my use thereof and my child's use thereof. I understand that use of the Facilities involves risks and dangers which include, without limitations, the potential of injury, disability, death, and other undefined harm or damage which may not be readily foreseeable (the "Risks"). I understand that these Risks may be caused in whole or in part by my own actions or inactions, the actions or inactions of my child, the actions or inactions of others using the Facilities, or the acts, inaction or negligence of the Released Parties defined below, and I hereby expressly assume all such Risks and responsibility for any damages, liabilities, losses or expenses which I incur as a result of my using, or my child using, the Facilities, as well as all responsibility for any damages, liabilities, losses or expenses which I cause, or my child causes, as a result of using the Facilities.

3. I hereby Release, Waive and Covenant Not to Sue, and further agree to Indemnify, Defend and Hold Harmless, the Company, its volunteers and employees (individually and collectively, the "Released Parties"), with respect to any liability, claim(s), demand(s), cause(s) of action, damage(s), loss or expense, including court costs and reasonable attorney's fees, of any kind or nature ("Liability') which may arise out of, result from, or relate to my use, or my child's use of the Facilities, including claims for Liability caused in whole or in part by the negligence of the Released parties.

4. I further agree that if, despite this Agreement, I, or anyone on my behalf, makes a claim for Liability against any of the Released Parties, venue for said claim shall be filed in St. Lucie County, Florida. This agreement shall be governed by Florida Law.

I hereby warrant that I have read this Agreement carefully, understand its terms and conditions, acknowledge that I will be giving up substantial legal rights by signing it (including the rights of my spouse, child, heirs and next of kin, and any legal and personal representatives, executors, administrators, successors and assigns of same), acknowledge that I have signed this Agreement freely and voluntarily, without any inducement, assurance or guarantee, and intend for my signature to serve as confirmation of my complete and unconditional acceptance of the terms, conditions and provisions of this Agreement. This Agreement represents the complete understanding between the parties regarding these issues and no oral representations, statements or inducements have been made apart from this Agreement. If any provision of this Agreement is held to be unlawful, void, or for any reason unenforceable, then that provision shall be deemed severable for this Agreement and shall not affect the validity and enforceability of any remaining provisions.

Legal Guardian Signature_____ Date_____

Waiver for the Distribution/Administration of Medication

<u>One form must be filled out for each medication.</u>

☐ **My child WILL NOT** take medication while at BBI Clinic *<u>Skip to bottom of form and complete name, date and signature portion</u> *

☐ **My Child WILL** take medication while at BBI Clinic and details are below. (a new form is needed for each medication)

This form must be complete and signed by the parent for the medication to be administered.

Child's Name: _____

Medication Start Date: _____ EXPIRATION DATE OF MEDICATION_____

Medication Name: _____Dosage: _____Refrigerate? ___Yes ___No

Time to be administered: _____ Reason for Medication: _____

BBI Staff initials: _____Date: _____

Physician Name: _____Physician Phone Number: _____

Name Of Practice: _____

Any prescription medications must be in the original pharmacy labeled container, and any over the counter medications must be clearly labeled with your child's first & last name. It is the caregiver's responsibility to ensure all medication be current and replaced by the expiration date. The undersigned hereby acknowledges and represents they are the parent, legal guardian, or person legally responsible for the above-named child is under the supervision of the programs sponsored and operated by Behavior Basics Inc.

The undersigned further acknowledges that they have requested that Behavior Basics Inc, its employees, and/or duly authorized agents administer or assist in administering the above indicated medication while the above-named child is under the supervision of Behavior Basics Inc.

Now, in consideration of the administering or assistance in administering said medication, the undersigned does hereby forever release, discharge, hold harmless and agree to indemnify Behavior Basics Inc. its employees and duly authorized agents of and from any and all claims, demands, suits, actions, and liabilities or responsibilities of whatsoever kind or nature, arising out of or in connection with the administering or assistance in administering of said medication.

Parent Name: _____

Parent Signature: _____Date: _____