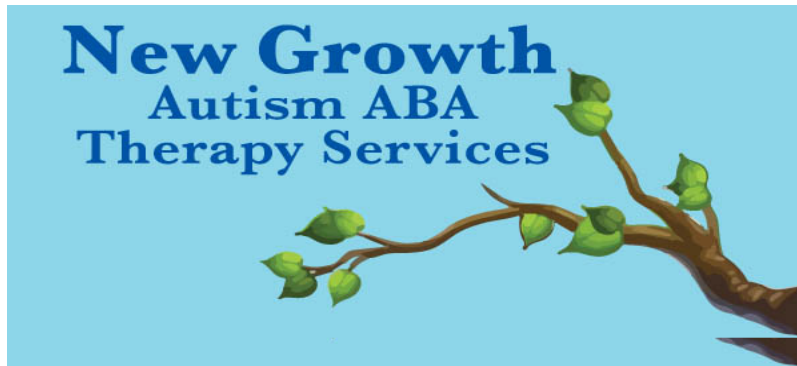


New Growth ABA



**New Growth ABA
52 Federal Ave.
Agawam, MA 01001
413-441-7914**

PROSPECTIVE CLIENT

SUBJECT: ABA SERVICES FOR YOUR CHILD

Dear Prospective Client,

Thank you for your interest in our company. Please complete the Client Registration Form to provide sufficient information to assess how we can be of service. Additionally, there is a Client Referral Form that can be completed by your Child's diagnosing professional. With these two documents we can begin to assess an appropriate path towards beginning treatment.

Once you have completed the documents, you can mail them, together with a copy of your insurance card(s), front and back and a prescription for ABA Services, if available, to the above address or email them to newgrowthaba@gmail.com. We are available for phone consultation should you have any questions.

Thank you again for your interest in our services and we look forward to working with you.

Sincerely,

Joanne Craig, Clinical Director

Mission

Our mission is to provide intensive treatment with the most effective, researched based therapy to make lasting changes in the lives of our clients. We believe in a total team approach to ensure that our clients are able to access the most appropriate services to meet their individual needs. New Growth ABA strives to provide the highest quality services for children and young adolescents with autism and other developmental disabilities. The emphasis is always client achievement and maximizing the individuals' potential in the home, school, and the community to create lasting change throughout their lives. New Growth ABA is dedicated to abide by the ethical standards outlined by the Behavior Analyst Certification Board.

An Overview of ABA Therapy

New Growth ABA, utilizes the principles of Applied Behavior Analysis and develops individualized programs or treatment plans that target cognitive, speech, language, academic or school readiness, behavior management, play, safety and social skills. Each individualized program is based on the child's strengths and work to decrease skill deficits.

Applied Behavior Analysis is the study of the functional relationship between one's behaviors and their environment. Data is collected on the stimuli that elicits, increases, decreases, or maintains the child's behavior. The data is analyzed and a treatment plan or an individualized ABA program is implemented. As the child's treatment progresses, data is collected and analyzed again to determine treatment effectiveness. The goal of a behavior analyst is to utilize behavioral contingencies to help the child learn more functional skills that can replace undesirable behaviors and improve quality of life. New Growth ABA seeks to produce significant results enabling the child to adapt to their environment thus preparing them for a brighter future.

Requirements for ABA Services

1. Complete Intake Packet
2. Obtain Pre-approval from your insurance company (if applicable); this is required prior to any evaluation, therapy, or other service being provided.
3. Have a Parent Meeting – This is for the development of a treatment plan and review of reports and goals
4. Schedule therapy sessions - Direct therapy will be conducted by a Registered Behavior Technician under the supervision of a BCBA or BCaBA
5. Have monthly meetings to review progress
6. Complete Quarterly/biannual assessments to continue to guiding instruction

Intake Packet Checklist

Not Yet Completed	Authorization to Release Information	Pg. 3
Not Yet Completed	Parent Guidelines	Pg. 4
Not Yet Completed	General Information	Pg. 5 & 6
Not Yet Completed	Professional Records; Patient Rights; Contacting Us	Pg. 7
Not Yet Completed	Permission to Videotape and Photograph	Pg. 8
Not Yet Completed	Client Registration Form	Pg. 9 & 10
Not Yet Completed	Diagnosis and Medications	Pg. 11
Not Yet Completed	Available Service Time Schedule and Behavior Concerns	Pg. 12 & 13
Not Yet Completed	Behavioral Language Assessment - Expressive Verbal Skills	Pg. 14
Not Yet Completed	Behavioral Language Assessment - Receptive Language Skills; Motor Imitation	Pg. 15
Not Yet Completed	Play Skills; Self Help Skills	Pg. 16
Not Yet Completed	Child's Education Background	Pg. 17
Not Yet Completed	Authorization to Bill Insurance	Pg. 18
Not Yet Completed	Authorization to Release Medical Information to Insurance Carrier	Pg. 19
Not Yet Completed	Informed Consent; Confidentiality Act - Abuse Reporting Protocol	Pg. 20
Not Yet Completed	Financial responsibility	Pg. 21
Not Yet Completed	HIPPA Service Agreement and Consent Form	Pg. 22
Not Yet Completed	IEP Sent	
Not Yet Completed	ETR (If Applicable)	
Not Yet Completed	Psychological Evaluation Sent	

New Growth ABA

AUTHORIZATION TO RELEASE INFORMATION

Student/Consumer Name: _____

DOB: _____

Street Address	City	State	Zip

I understand this release is voluntary and applies to all programs and services operated under the auspices of New Growth ABA. I understand that my *personally identifiable information* (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. **I understand that I may revoke this authorization at any time by notifying New Growth ABA in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.**

I hereby authorize New Growth ABA to (Choose all that apply):

- ☐ Exchange with **the parties I indicate below.**
- ☐ Release to **the parties I indicate below.**
- ☐ Obtain from **the parties I indicate below.**

I hereby authorize New Growth ABA to exchange / release / obtain information:

- ☐ Verbally only ☐ In written form only ☐ Both verbally and written form

Organization or Individual receiving/communicating the information:

Name of Organization/Individual

Address	City	State	Zip	Phone

Description of information to be exchanged / released / obtained:

Click to Select Answer Education records

Click to Select Answer Evaluation/assessment/eligibility records

Click to Select Answer Medical records

Click to Select Answer Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)

Click to Select Answer

Other: _____

Duration of release (choose one):

Click to Select Answer

This release will remain in effect for (2) years, unless otherwise stipulated or revoked in writing

Click to Select Answer

This release will remain in effect from _____ to _____

(MM/DD/YYYY)

(MM/DD/YYYY)

The purpose of this release is:

Signature of Student/Consumer/Patient or Legally Authorized Representative

Date (MM/DD/YYYY)

Parent/Guardian Guidelines

Your cooperation on the following is greatly appreciated to assist us in working with your child effectively and efficiently:

- A parent or responsible adult must be in the home during therapy sessions.
- Your child should be dressed and fed prior to therapist arrival unless these skills are being addressed in the program.
- If sessions are in the home, the area being used for therapy must be a comfortable temperature, smoke free, well-lit and relatively free of distractions. It is important that we are able to conduct the session in a professional manner with materials ready and limited access to competing reinforcers (i.e. toys that are not used during the therapy session).
- The therapist must wait 15 minutes if child is not there at the therapy time and then is permitted to leave.
- The therapist will call the family if they are going to arrive more than 5 minutes late.
- A therapist cannot change appointment times without agreement with the family.
- If your family is planning an extended vacation (more than 2 weeks), please inform the therapist and supervisor. We will continue to reserve the spot for your child, but cannot guarantee that your child will work with the same therapist.
- Sickness. *Please notify the therapist, as much in advance as possible, at least the night, before the scheduled session if you know that your child (or other children in your home) will not be able to participate in the program the next day due to illness.*
 - Sickness includes, but not limited to the following: Temperature above 100, Cold, Strep Throat, Hand/Foot/Mouth, Vomiting, Measles, Mumps, Chicken Pox, Diarrhea, Pin Worm, Lice, Rash, Pink Eye, and Cough
 - Parents are asked to use the same guidelines used in a school – if a child (or sibling) is too sick to attend school, he or she is too sick to participate in his/her therapy session.
 - Therapy will resume as soon as the child's doctor clears him/her of being contagious or the remedy is completed. If a therapist arrives at the home and the child is sick, the therapist will not be able to work with your child.
- The therapist is NOT allowed to take a child in their automobile.
- Parents and consultants/therapists should be respectful and courteous to each other. Open communication between parents and consultants/therapists is essential to the establishment of a successful program for the child. If there are any problems or concerns, please contact the Chief Clinical Officer immediately.
- Please understand that all information shared is HIPPA protected, it is essential that every employee respects and maintains each client's right to confidentiality regarding his or her treatment and all personal information. All HIPPA laws apply. Please do not ask about another client's program or treatment, as this information will not be discussed and could possibly lead to the dismissal of your child from the program.

Parent/Guardian Initials

General Information

Scheduling and Sessions

Each client will have a Board Certified Behavior as the lead supervisor for their treatment. A Behavior Technician will provide direct 1:1 therapy in the designated setting. Each Behavior Technician has at an experience providing services to children with Autism.

Sessions for in-home ABA are usually scheduled in one to three-hour blocks. A parent/legal guardian or adult over the age of 18 is required to be present and available in the home throughout the therapy session(s).

Except in cases of emergency, 24 hours' notice is required for all canceled appointments. We request that families give us at least two weeks' notice on significant changes in their plans for in-home ABA sessions scheduling to facilitate consistency in service delivery. The universal standard for therapy that the last 15 minutes of each session is devoted to data collection, note writing, material preparation/organization for the following session and discussion of session with the parent.

Services and Discharge

To determine the program needed for a client we initially complete an assessment to determine whether a client would benefit from our services. After it has been determined that our services are needed, a BCBA is appointed as the team leader and develops a treatment plan based on the findings of the assessment.

The treatment plan includes general and specific goals with time frames for completion. The treatment plan also includes a scheduled reassessment generally six months from the time the treatment plan is developed. The treatment plan is then implemented by the BCBA who supervises Behavior Technicians on proper implantation of the treatment plan.

Once the client has attained the level of development similar to a typical developing child, the client will be put on a maintenance program until the BCBA determines services will no longer benefit the client. Being a sudden stop in services can be detrimental to the skills acquired, the discharge from services is done over a long period of time to achieve a smooth transition.

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 necessitates the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you speak to our staff personally and give 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 (\$50) for appointments missed or canceled with less than 24 hours advance notice. Please note that most insurance companies will not reimburse you for missed appointments and you remain responsible for these charges.

Parent/Guardian Initials

Confidentiality, Records, and Release of Information

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 agencies.

Family Engagement

New Growth ABA, strives for excellence in its ABA program and an integral component to achieve that goal is family involvement. When possible, parents/guardians carry over the therapy being implemented and record data for specific programs as outlined in the client treatment plan.

If the Client/Family refuses involvement in the treatment plan, as a last resort services may be suspended or terminated based on the severity of the lack of involvement. Without the client/family involvement our treatment plans will not be as effective as possible.

To Protect the Client or Others from Harm

If we have reason to suspect that a client or other minor 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 DCF, the police, and intended victim, a minor's parents, or others who could provide protection, or seeking appropriate hospitalization.

Professional Consultations

Behavior Analysts routinely consult about cases with other professionals. In doing so, 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. We will inform clients of these consultations. If you want us to talk with or release specific information to other professionals with whom you are working, you will need to sign an authorization specifying what information can be released and with whom it can be shared.

Supervision Requirements for Private Pay Clients

BCBAs do not require supervision. Programs implemented by Behavior Technicians require 1 hour of supervision per every 8 hours of direct instruction.

Cancellation and Late Fees

Cancellations with less than a 24-hour notification: If 3 or more cancellations occur within a month's time, termination of services may occur.

Payment Options

We accept the following forms of payment: **Cash** or **Check** (made out to New Growth ABA).

Parent/Guardian Initials

Professional Records

You should be aware that, pursuant to HIPAA, we keep clients’ Protected Health Information in one set of professional records. The Clinical Record 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. Personal notes are taken during supervision sessions by the Behavior Technician. While the contents of personal notes vary from client to client, most are anecdotal notes related to progress and future goals, reference to conversations, and hypotheses of the professional. These Personal Notes are kept separate from the Clinical Record are not available to you and cannot be sent to anyone else, including the insurance company. Your signature below waives all rights, now and in the future, to accessing these records in any form under any circumstances. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Patient’s 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 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 you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints made 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 their many professional commitments, our professionals are often not immediately available by telephone. If you need to leave 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 your availability within the message. In emergency or crisis situations, please contact your physician, or call 911, and/or go to the nearest hospital emergency room.

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms described above.

	Client’s Name
	Parent/Guardian Printed Name
	Date

	Parent/Guardian Signature
--	---------------------------

Permission to Photograph

Client's Name		DOB	
		(MM/DD/YYYY)	

I give permission and consent for New Growth ABA, to photograph my child and/or myself during the time my child is enrolled in services. I understand these photographs may be used in educational training presentations.

Parent/Guardian Signature		Date	
---------------------------	--	------	--

Permission to Videotape or Audiotape

I give permission and consent for New Growth ABA, to videotape and/or audio tape my child and/or myself during the time my child is enrolled in services. I understand these tapes will not be used outside the company and will be kept confidential. I understand that the tapes will be used for the purposes of developing more effective educational and therapeutic plans for my child and also for the purpose of education and training for New Growth ABA.

Parent/Guardian Signature		Date	
---------------------------	--	------	--

Client Registration

Client Name

Client Address

Street

City

State

Zip Code

--	--	--

Client Social Security Number

Client Gender

Client Date of Birth

Parent/Guardian Name

Parent/Guardian Address

Street

City

State

Zip Code

--	--	--	--

Date of Birth

Email

Home Phone

Cell Phone

Occupation

--	--

--	--

Employer

Group Number

--	--

Primary Coverage

Secondary Coverage

Parent/Guardian Name

Parent/Guardian Address

Street

City

State

Zip Code

--	--	--	--

Date of Birth

Email

Home Phone

Cell Phone

Occupation

--	--

Employer	Group Number
Primary Coverage	Secondary Coverage

Other Insurance Coverage:

Policy Holder	
Insurance Carrier	
Insurance Policy Number	
Insurance Group Number	

Siblings/Household Members other than parent/guardian

Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth

Emergency Contact Information

Name:		Phone Number:		Relationship to Child	
Name:		Phone Number:		Relationship to Child	

Other Services Provided (Speech/PT/OT, etc.)

Name of Provider		Services Provided	
		Times per Week	
Name of Provider		Services Provided	
		Times per Week	
Name of Provider		Services Provided	
		Times per Week	

Diagnosis

Primary Diagnosis 1:		Diagnosis Date:	
Diagnosing Professional:			
Primary Diagnosis 2:		Diagnosis Date:	
Diagnosing Professional:			
Primary Diagnosis 3:		Diagnosis Date:	
Diagnosing Professional:			
Medical Conditions: (if any)			
Allergies:			
Special Diet Information:			

Medications

Medication	Dosage	Frequency

What are your goals and/or expectations for the services requested?

1.

2.

3.

Available Service Times:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start Time Start Time Time End Time End Time	Start Time Start Time Time End Time End Time	Start Time Start Time Time End Time End Time	Start Time Start Time Time End Time End Time	Start Time Start Time Time End Time End Time	Start Time Start Time Time End Time End Time	Start Time Start Time Time End Time End Time

Behavior Concerns

Behavior 1 (Please Describe)	
Severity of Behavior	Severity of Behavior
How often does this behavior happen?	Frequency of Behavior
Behavior 2 (Please Describe)	
Severity of Behavior	Severity of Behavior
How often does this behavior happen?	Frequency of Behavior
Any other behaviors to be noted?	

What situations are these behaviors MOST likely to occur? (Days/times/settings/activities/persons present)

What situations are these behaviors LEAST likely to occur? (Days/times/settings/activities/persons present)

What typically happens right BEFORE problem behavior occurs?

What typically happens right AFTER problem behavior occurs?

What treatments have been implemented in the past?

What motivates/interests your child?

Please list any other important information you would like us to know about your child.

Behavioral Language Assessment Expressive Verbal Skills	
Describe your child's ability to babble speech sounds:	
Describe your child's spontaneous language:	
Describe how your child indicates what they want:	
Describe the type and number of items that your child asks for:	
Describe your child's ability to imitate vocal sounds, words, phrases:	
Describe your child's ability to label items, events, or actions (spontaneous? How many? How often?):	
Describe your child's ability to answer questions:	

Behavioral Language Assessment Receptive Language Skills	
Describe your child's ability to follow directions and routines within context or with model:	
Describe your child's ability to follow directions and routines out of context or without a model:	
How many items is your child able to identify receptively?	
Is your child able to select an item from a field of two or more when given a description of the item?	

Motor Imitation						
Is your child able to imitate simple motor movements such as clapping, waving?						Yes or No?
Is your child able to imitate actions using objects---using "do this" with a model?						Yes or No?
Your child makes eye contact with:	•	•	•	•	•	
	Mom	Dad	Siblings	Familiar People	Others	
Describe your child's response when addressed by others:						
Describe your child's interest in doing what others are doing:						
Describe your child's ability to participate in turn-taking activities:						

Is your child conversational? Yes or No? Describe:	
Does he/she get “stuck” on certain topics? Yes or No? Describe:	

Play Skills	
Describe your child’s play with toys (identify the toys and length of time involved):	
Does your child use the toys as intended or as self-stimulatory objects?	
Describe your child’s interactive play with other children:	
Describe your child’s imaginative and pretend play skills:	

Self-help Skills	
Describe how your child feeds him/herself:	
Is your child toilet trained completely?	Yes or No?
If not, what program did you use or have you tried with your child?	
Does your child dress independently: Yes or No? Describe:	
Describe any household tasks that your child assists with:	
Describe how your child responds to situations of danger:	

Child's Educational Background:

School:

Grade:

Grade

Home School •	Life Skills •	Emotional Support •	General Education •	Autism Support •	Learning Support •
Private School •	Speech and Language •	Occupational Therapy •	Physical Therapy •	APE •	
Contact Name:				Phone Number:	

Please attach the most recent copy of your child's IEP, RR, ETR, FBA, and/or BIP.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to New Growth ABA. I understand that I am financially responsible for any balance. I also authorize New Growth ABA or insurance companies to release any information required to process my claims and to establish service eligibility/authorizations.

Client's Name

DOB (MM/DD/YYYY)

Parent/Guardian Printed Name

Date

Parent/Guardian Signature

AUTHORIZATION TO BILL INSURANCE

Client's Name

DOB (MM/DD/YYYY)

I, _____ hereby give my consent for New Growth ABA to bill my/my child's insurance carrier for the services rendered to my child by the above- mentioned provider. In addition, I agree to pay New Growth ABA any deductible or uncovered charge in accordance with my health care plan.

Parent/Guardian Printed Name

Date

Parent/Guardian Signature

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INSURANCE CARRIER

I understand that my express consent is required to release any health care information relating to assessment and treatment. I, _____ hereby give my consent for New Growth ABA to release medical and other relevant information to our insurance carrier as required by my/our insurance carrier to process medical billings.

Parent/Guardian Printed Name

Date

Parent/Guardian Signature

INFORMED CONSENT

I, _____, agree to have my child

evaluated/treated through New Growth ABA. I understand that these services are based on an applied behavior analysis (ABA) model and will be provided by a professional trained in ABA. I understand that state laws may require that confidentiality be broken under certain circumstances, specifically, if I am judged by the behavior analyst to be of danger to myself and/or others, gravely disabled, or if there is suspected child abuse.

I also understand that New Growth ABA specializes in the evaluation and treatment of problem behaviors as well as skill acquisition, and if New Growth ABA is unable to meet my particular needs, I will be referred to an appropriate agency or individual.

Services: New Growth ABA implements the Applied Behavior Analysis for its services. A variety of techniques are integrated and utilized during treatment. You will be encouraged to practice various skills introduced in sessions. A treatment plan with specific goals will be explored and updated according to treatment plan schedules. Recommendations for additional treatment and/or intensive treatment may be made, if needed. **When a client is a minor under the age of 14**, parent involvement is required during all visits with the Client. Information will be limited to accommodate confidentiality with children of all ages. Family involvement is an important part of treatment. Children under the age of 18 will require a parent's signature (or legal guardian) to receive any form of treatment.

Concerns about services may be directed to:
Joanne Craig, Clinical Director, jocraignelson@yahoo.com, 413-441-7914

Parent/Guardian Signature

CONFIDENTIALITY ACT – ABUSE-REPORTING PROTOCOL

Parent/Guardian Name:

I understand all information related to the above-named client's assessment and treatment must be handled with strict confidentiality. No information related to the client, either verbal or written, will be released to other agencies or individuals without the express written consent of the client's legal guardian. By law, the rules of confidentiality do not hold under the following conditions:

1. If abuse or neglect of a minor, disabled, or elderly person is reported or suspected, the professional involved is required to report it to the Department of Children and Families for investigation.
2. If, during the course of services, the professional involved receives information that someone's life is in danger, that professional has a duty to warn the potential victim.
3. If our records, our subcontractor records or staff testimony are subpoenaed by court order, we are required to produce requested information or appear in court to answer questions regarding the client.

Parent/Guardian Printed Name

Date

Parent/Guardian Signature

FINANCIAL RESPONSIBILITY

Client Name:

DOB (MM/DD/YYYY):

- Clients who do not have any insurance coverage are expected to pay on a monthly basis. An invoice will be sent at the beginning of the month following services with an expectation payment is received by the end of the month. A sliding scale may be implemented to accommodate any financial difficulties on a case-by-case basis.
- Clients who are currently covered by insurance: The client is responsible to provide valid insurance information, and should provide their insurance card each visit.
- It is important for you to make sure we are in-network and we are currently a provider with your insurance company.
- If we are currently a provider with your insurance company, the necessary forms will be completed and submitted, and secondary insurances will be billed when applicable.
- Any medical services not covered by an individual's insurance plan are the client's responsibility and payment in full is due at the time of the visit. Specific coverage issues should be addressed by the insurance company's member services department (telephone number is on the card).

If you are covered by an HMO or Managed Care Plan:

- The client is responsible to pay any co-payment or any portion of the charges as specified by the plan mentioned above.
- The client is responsible to ensure that any required referrals for treatment are provided to the practice at the time of the visit. Visits may be rescheduled, or the patient may be financially responsible due to the lack of the referral.
- WE reserve the right to charge the completion of forms and letters. For example, insurance, or different programs, and the copying of records.
- Any outstanding balance either not paid in full or under a payment plan agreement can be transferred to an outside collection agency.

A "no show"/late cancellation fee may be charged to clients who do not provide at least 24-hour notice for canceling scheduled appointments or who fail to keep scheduled appointments without calling to notify the scheduling secretary or clinician.

Parent/Guardian Signature

Date

Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

This notice describes how protected health information about a client may be used and disclosed and how the client can gain access to this information. Please review it carefully.

New Growth ABA understands we collect private and/or potentially sensitive medical information about each client and/or the client's family. We call this information "protected health information." This notice explains the client's privacy rights and addresses how New Growth ABA may use and disclose protected health information. New Growth ABA does not use or disclose protected health information unless permitted or required to do so by law. New Growth ABA must adhere to laws aimed at securing the privacy of the client's protected health information. These laws are known as the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. When we do use or disclose protected health information, we will make every reasonable effort to limit its use or the level of disclosure to the minimum we deem necessary to accomplish the intended purpose. Please note that the privacy provisions articulated in this notice do not apply to health information that does not identify the client or anyone else.

For more information on New Growth ABA privacy practices, or to receive another copy of this notice, please contact: New Growth ABA, 52 Federal Ave. Agawam Ma 01001-2121. (413) 441-7914