

## Social Thinking® Clinical Therapy

### What you will receive from our program

Our adult sessions will provide opportunities for our clients to explore concepts and develop tools to address various areas of Social Thinking. Some of those areas are:

- Perspective taking
- Personal problem solving
- Social communication and advanced social relationship skills for use in the work setting, home, college campus and community.
- Self-advocacy
- Related social anxiety
- Organizational skills
- Emotional expression

Many adults are seen in individual sessions to explore their very specific individual needs. However, we also provide Social Thinking group treatment if we find clients who are a good match for one another. We DO NOT group people simply by a diagnostic label or by the time slot they are available to come to our clinic. Instead, we thoroughly review all the information we have available to determine if and when we have a match for a group. We prefer to meet adults first or at least talk to them over the phone before determining what type of session is best (group or individual). If you have previous treatment or diagnostic reports available, please attach a copy as well as a written letter from you or a trusted friend or family member. This will help us better understand why you are seeking treatment. We work hard to develop and provide appropriate individualized treatment to foster social learning and anxiety management. Regular attendance for individual or group sessions is key.

### Social Thinking Boston is an International Training Center:

Social Thinking Boston (STB) hosts clinicians from around the world through our Social Thinking Clinical Training Program. Clients may be observed in their groups from the observation rooms by our trainees. Client confidentiality is maintained throughout all training programs. Please feel free to discuss these programs with your therapist if you have any questions. Signs will be posted each week we have visitors in from around the world.

**Enrollment in Social Thinking Groups:**

We group clients with peers that function similarly in his/her cognitive, perspective taking, social language and auditory processing abilities. We see over 125 clients on a weekly basis so finding common times for similar clients to be scheduled can be a difficult puzzle to solve. To help with the process we encourage you to provide as many possible times and days to allow the most options when scheduling. This significantly increases the chances that you will be placed in a group.

**Attendance Policy for Social Thinking Groups:**

Group work is dependent on all group members attending sessions regularly. Groups run from September to mid-June and your group will be most effective when everyone attends consistently. This allows you to build peer rapport and develop peer accountability. Applicants must make every effort to attend on a weekly basis. Our clinic calendar details specific holiday closures and over the course of the school year you will have 2 excused absences. You can use these 2 days without being charged for missing your group time at the clinic. Beyond that, missed sessions will be billed as regular sessions.

On the rare occasion that everyone is absent from the group except for one client, we will still hold the session and focus on your specific needs the therapist has observed. This is a good opportunity since we wish we had some individual time to work with all of our clients. The session will still be billed at the group therapy rate. We will not call you to let you know that you will have an individual session, as we don't often hear about absences until the day of. If you choose to not come for the session knowing another group member is out, this will count as one of the two excused absences or will be billed as a missed session if you have exceeded the allowable absences.

**Individual Therapy:**

Individual therapy sessions for adult clients occur before 3pm. Individual therapy sessions are offered as space allows on the therapist's schedule.

**Program Cost:**

\$105 per 60-minutes when 3 – 4 clients in the group  
\$125 per 60-minute when 2 clients in the group  
\$155 for individual session  
\$155 per hour for additional consultation with parents, spouse or partner, report writing, or phone calls exceeding 10 minutes with a therapist.

**Billing:**

STB is an independent business. Billing/invoicing will be explained upon placement in a group. We do not sign contracts with insurance companies, nor do we accept payment directly from insurance companies.

**Insurance Policy:**

We do not process any insurance. However we do include procedure codes on our invoices based on the type of session to assist you with claims you may wish to submit for reimbursement from your insurance company. For more information on our policy regarding insurance claims please call our office at (978) 601-6003.

**Deposits:**

A good deal of time is invested in considering each client's placement. A deposit of \$105 should be sent in with the application for placement. This money will then be applied to the client's first week in the program. If the client applies to the program and we find a placement for them but then the client decides to not accept the placement for therapy, \$50 from the deposit will not be refunded. If we are not able to place the client, the deposit will be refunded in June.

**All Clients:**

- Registration Form
- Clinic Policies
- Report(s)/Outside Info/any other information which will give us a better understanding of your strengths and challenges
- \$105 Deposit payable to Social Thinking Boston. The deposit will be applied to the last two weeks of program attendance. (If the deposit poses a burden please contact our office to discuss possible arrangements.)

**In addition, new clients please include:**

- New Client Information Form
- A brief letter from you and/or a family member describing your strengths and challenges. (See below for letter guidelines).
- Report including medical diagnosis or letter from doctor (not required but helpful if seeking insurance reimbursement)

Please mail complete applications to:

Social Thinking Boston  
142 North Road, Suite SS  
Sudbury, MA 01776

*Faxed or emailed applications cannot be accepted.*

**Notes about completing your application:**

- **The attached registration form must be filled out completely even if you have attended sessions at our clinic before!** Remember, the more time slots you make available for us to choose from, the more likely it will be that we are able to place you in our clinic.
- Please be aware that our receipt of your application does *not* guarantee placement in a group nor should it be assumed that because you attended last year you will automatically be enrolled without an application. Group placement is primarily based on matching similar clients together for the best possible group interaction and time when the group can meet together.
- New clients must include a letter and any relevant reports. Our therapists will not be able to create a profile and therefore determine placement without this extra information.
- It is important to be as precise as possible, this part of scheduling is complicated and we rely on the information you provide us. We will make every attempt to meet your needs.
- Those who do not make it into one of the initial groups will be placed on the waiting list & contacted when an opening occurs; we generally are able to place the majority of applicants in groups if we receive the applications by the **deadline of July 12, 2013**

**PLEASE WRITE A BRIEF LETTER DESCRIBING YOUR STRENGTHS AND CHALLENGES.**

Including information about the following areas helps us obtain a clear picture of your needs, which will increase our ability to find an appropriate placement. If you are a returning client, only include a letter if there are changes you would like us to keep in mind. Please include the following in your letter:

- Your strengths and challenges related to functioning in the social world
- Describe your interactions with peers, family, employer/employees etc.
- Describe your own awareness of these challenges (e.g., Are you aware of how others perceive you? Do you think that you are perceived as "different" from your peers?)
- How well do you understand that your actions and words affect others?
- How do you respond to every day problems, such as changes in the schedule, peer or employment conflicts etc?



**ADULT REGISTRATION FORM**  
FALL/SPRING 2014-2015

For admin use only:

For therapist use only:

RETURN COMPLETED APPLICATION AND FORMS BY JULY 12<sup>TH</sup> FOR FIRST CONSIDERATION

Returning Client?  YES  NO

First Name Last Name Gender Age Date of Birth

Street Address City State Zip Code

Daytime Phone Cell Phone Email

**BILLING INFORMATION:**

- I am responsible for my own charges. Please mail invoices to the above address.
- Please mail invoices to the person listed below:

First Name Last Name Relationship

Street Address City State Zip Code

Daytime Phone Cell Phone Email

**MY MOTIVATION FOR SEEKING TREATMENT**

- Help holding/getting a job
- Social networking and developing social relationships in the community and/or at work
- Learning coping and Social Thinking & related social skills for use on a college campus
- Organizational skills
- Specific vocational and life skills training for living with increasing independence at home, work and community
- Other: \_\_\_\_\_

**PLEASE CIRCLE YOUR AVAILABILITY**

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
9:30 am	9:30 am	9:30 am	9:30 am	9:30 am	
10:45 am	10:45 am	10:45 am	10:45 am	10:45 am	11:30
1:00pm	1:00pm	1:00pm	1:00pm	1:00pm	
2:00 pm	2:00 pm	2:00 pm	2:00 pm	2:00 pm	
3:00 pm	3:00 pm	3:00 pm	3:00 pm	3:00 pm	
4:00 pm	4:00 pm	4:00 pm	4:00 pm	4:00 pm	
5:00 pm	5:00 pm	5:00 pm	5:00 pm	5:00 pm	
6:00 pm	6:00 pm	6:00 pm	6:00 pm	6:00 pm	

**SESSION TYPE**

- Group sessions
- Individual sessions
- Group AND individual

**PREFERRED THERAPIST OR GROUP MATES**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**JOB/CAREER**

I am currently employed  full-time  part-time at: \_\_\_\_\_  
Employer/Company Name  
Number of hours I work: \_\_\_\_\_ Located in: \_\_\_\_\_  
City, State

Please describe any current concerns you have regarding your employment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EDUCATION**

I am currently attending school:  full-time  part-time at: \_\_\_\_\_  
General class schedule: \_\_\_\_\_  
\_\_\_\_\_

Major: \_\_\_\_\_  
Highest level of education completed:  High School  Junior College  Trade College/University  
 Degree(s): \_\_\_\_\_

Please describe any current concerns you have regarding your schooling: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there someone at school that we may contact?

_____	_____
Contact Name	Phone Number
_____	_____
Title of contact person	Email address

**EMERGENCY CONTACT INFORMATION**

\_\_\_\_\_ Phone \_\_\_\_\_  
Print Name of Emergency Contact  
\_\_\_\_\_  
Relationship to client

**Please check all that apply**

<input type="checkbox"/>	I am living independently (in my own home/apartment)	<input type="checkbox"/>	I am responsible for my own expenses
<input type="checkbox"/>	I am living in my parent's home	<input type="checkbox"/>	I have a roommate/housemate and share expenses
<input type="checkbox"/>	I am married. Number of years? ____	<input type="checkbox"/>	I have other living arrangements
<input type="checkbox"/>	I have children	<input type="checkbox"/>	I am divorced
<input type="checkbox"/>	I get financial assistance for my expenses		

If you would like to have a medical diagnosis included on your billing statements for insurance reimbursement, please include a report or letter indicating your medical diagnosis.

Diagnosis: \_\_\_\_\_ Diagnosing clinician: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Who referred you to our program? \_\_\_\_\_

Please describe why you are seeking assistance from our clinic: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Optional:**

Occasionally in the course of recording the sessions we will capture an interaction that accurately illustrates a particular concept or strategy of the Social Thinking philosophy. In this instance we would like the opportunity to use this video in a training/conference setting. The video will be used to educate fellow parents and professionals about how to employ therapy techniques that are being discussed.

**Sign here only if you are comfortable with this option:**

I give permission for video or pictures of me/my child to be used in **both** clinical & conference settings.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print name

**I agree to follow the fee schedule and policies as noted:**

**Therapy session fee schedule:**

- \$110.00 per 60-minutes when 3 – 4 clients in the group.
- \$130.00 per 60-minutes when 2 clients in the group.
- \$160.00 for individual session.

**Additional consultation:** \$155.00 per hour for consultations, report writing, or phone calls exceeding 10 minutes with a therapist.

**Please Initial Every Section**

\_\_\_\_\_ **Absences and Missed Sessions:**

If you started therapy with us in Fall, you will be permitted **two** cancellations for the Fall/Spring program without being billed for those cancellations. If you started therapy with us after January 31st, you will be permitted **one** cancellation. Cancellations may be due to illness, schedule conflicts, vacations, etc. Unfortunately, if you miss more than the allowed absences you will be billed at your regular rate. If you find you cannot continue at the clinic for any reason, we require a two week notification of withdrawal to allow our staff time to fill that slot.

\_\_\_\_\_ **Policy for reduced group attendance:**

When therapists work in the group, they observe small details in you that they are not always able to address in depth at that moment given the group setting. When all the other clients in the group are absent, we will see you in an individual session, at the same price as if it was a group session. This is an excellent time for giving you some direct feedback and encouragement. However, it is not a choice to cancel this session without the absence being noted as a cancellation.

\_\_\_\_\_ **Recordings for therapeutic purposes:**

The use of video, picture image and audio recordings are an essential component to Social Thinking® therapy. We must be allowed to use these types of recordings in order for you to participate in our program.

\_\_\_\_\_ **Acknowledgement of Observations:**

Social Thinking Boston is committed to continuing to train professionals from all over the world the Social Thinking conceptual model and techniques. Groups run by our clinics will be at times observed by trainees enrolled in the Social Thinking professional development program. Trainees enrolled in the advanced training may also participate in treatment sessions.

Confidential information about you will not be shared with the trainees beyond what they may need to know in order to plan an effective lesson.

\_\_\_\_\_ **Policy for processing insurance claims or other administrative tasks:**

We are a “private pay” clinic, meaning that all of our services must be paid for by the guardians of the client, or the adult client themselves. We do not accept 3rd party reimbursements. We recognize that obtaining insurance coverage may be a difficult process and we wish to do what we can to make this difficult process easier. We strongly encourage families to keep their own copies of their invoices and any reports or written updates we send to them each month.



- 1) We do NOT process insurance claims on behalf of a client or family. Our role is to provide records when and if they are requested by a family in order for the client/parent to submit such claims to their respective insurance company.
- 2) Some insurance companies will only reimburse for specific ICD9 Diagnostic Codes. On your monthly billing statement, we include the diagnostic code from any medical reports provided by the client. We cannot enter a medical diagnostic code based on an educational classification alone. For any client that does not have a medical diagnosis on file we will use the default code, ICD9: 799.90 Deferred on Axis I (a non medical insurance code). Our statements also include a procedure code to reflect the service provided (group speech therapy or individual speech therapy).
- 3) Due to the intensive time and cost related to gathering information for an insurance claim, we will charge an administrative fee based on \$40.00 per hour for any administrative requests which include copies of previous invoices, reports, therapy notes, or calls to insurance companies.
- 4) We will not sign any contract offered to us by an insurance company that states that we agree to be paid a lesser fee than what we have established as our fee for service, even if the parent has paid our insurance administrative fee.

\_\_\_\_\_ **Policy for billing:**

Billing statements/invoices are issued at the end of each month for weekly therapy sessions. Payment is due upon receipt and is considered past due if not received by the 25th of the month. Once your account becomes delinquent, payment will be requested at the end of each therapy session.

*Payment in full is the responsibility of the client, whether or not insurance is pending.* There is a \$25.00 charge for returned checks.

Open accounts of 30 days or older will bear interest at 10% per annum and will result in temporary suspension in therapy until payment in full has been received or a payment plan has been agreed to.

Accounts that are unpaid for six or more months may be assigned to a collection agency.

If you are unable to make your full payment, please contact your clinic to arrange a payment schedule.

Please email Elena Kleifges at [ekleifges@socialthinkingboston.com](mailto:ekleifges@socialthinkingboston.com) with your payment information.

\_\_\_\_\_ Initial indicates that I have read/received a copy of the Social Thinking Privacy Policy (see attached).  
Please retain a copy of our Privacy Policy for your file.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



It is important that you review this information, initial the box on the policies signature page and keep this for your records.

This notice describes how information about our patients/clients may be used and disclosed and how they can obtain access to this information.

**Terms:**

Any medical information, which could in any way identify an individual client, is considered **Protected Health Information (PHI)**. PHI will be used and disclosed only as needed for Social Thinking (ST) to perform **\*Treatment, Acquire Payment and Health Care Operations (TPO)**. Any other disclosure will require the written authorization of the client. In general, use or disclosure of PHI for purposes other than treatment, or a disclosure requested by the client, is limited to the **Minimum Necessary** to accomplish the intended purpose.

*(\*TREATMENT: ST PHILOSOPHY INCLUDES A TEN MINUTE "GROUP" PARENT MEETING AS A PART OF EACH GROUP SESSION TO DISCUSS WHAT HAPPENED DURING THE SESSION. DURING THIS TIME IT IS UNDERSTOOD THAT THE THERAPIST WILL SPEAK OPENLY TO ALL THE PARENTS ABOUT ALL THE CLIENTS IN THE GROUP WITH REGARD TO THEIR PARTICIPATION AND THINGS THEY NEED TO WORK ON AT HOME. THE THERAPIST WILL MAKE EVERY ATTEMPT TO HAVE THESE DISCUSSIONS IN A PRIVATE SETTING.)*

**Access:**

The following people will have access to PHI:

- ⊕ The client when 18 years old or older.
- ⊕ Parents or legal guardians of a minor.
- ⊕ Parents of an adult client with written permission of client.
- ⊕ Any person to whom the adult client has authorized, in writing, the release of PHI.
- ⊕ ST staff and contractors who are involved in providing care or administrative assistance.
- ⊕ The client's health insurance company, for payment purposes.
- ⊕ Public Health Services and regulatory officials, when required by law.
- ⊕ An appropriate authority when a determination is made that the client may pose physical threat to themselves or others.
- ⊕ Courts, when the request is accompanied by a duly executed subpoena.

**Minimum Necessary:**

Requests for disclosure of PHI for all purposes will be reviewed by the ST Privacy Contact to assure that they meet the minimum necessary requirement.

**Patient/Client Rights:**

- ⊕ Parent/Guardian of clients or adult clients have a right to see and obtain a copy of their PHI.
- ⊕ Clients have a right to request limitations to the routine use of PHI for TPO.
- ⊕ Clients have a right to request changes in their PHI.
- ⊕ Clients have the right to see a list of all people to whom PHI has been disclosed. In order to meet this requirement, the Therapist must keep a disclosure log. The log must record all disclosures, both written and verbal.

**Security:**

Privacy measures are designed to protect the confidentiality of all PHI:

- ⊕ All staff will receive instruction about and be familiar with the ST Privacy Policy.
- ⊕ All Staff will exert due diligence to avoid being overheard when discussing PHI.
- ⊕ All records will be maintained in a secure environment.

**Information with regard to grievances:**

Clients who have complaints or concerns with regard to therapeutic management, please first contact your therapist to discuss your concern. If you feel that she has not been able to adequately address your needs, then please contact the Clinical Services Manager. For all other questions, concerns or complaints please address them to the ST Office Manager. If the office manager cannot handle them directly, she will bring them to the attention of the relevant employee at the ST. If you still feel that your complaint has not been resolved to your satisfaction, you can address complaints to the Secretary of the United States Department of Health and Human Services. Social Thinking will not retaliate against any individual for filing a complaint.

**Administration:**

- ⊕ The ST Office Manager serves as the Privacy Contact.
- ⊕ A designee of the ST serves as the Center Security Officer.

**Additional Resources on Health Information Privacy**

Health Privacy Project  
Georgetown University  
[www.healthprivacy.org](http://www.healthprivacy.org)

Office for Civil Rights  
U.S. Department of Health & Human Services  
[www.hhs.gov/ocr/hipaa/](http://www.hhs.gov/ocr/hipaa/)

Please initial the box at the end of the ST Therapy Policies & Procedures contract indicating you have read and understood these privacy policies.