Social Thinking® Clinical Therapy

What you will receive from our program

Our sessions 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
- Organizational skills
- Emotional regulation
- Social communication skills for use in the school, home, and community

We provide Social Thinking group treatment for students who are a good match for one another. We DO NOT group people simply by diagnostic labels 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 children 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 describing your child's social needs. This will help us better understand why you are seeking treatment. We work hard to develop and provide appropriate group and individualized treatment to foster social learning and emotional regulation. Regular attendance for individual or group sessions is key. We develop goals and objectives and provide a progress update on a regular basis (quarterly).

Intakes

If you decide to enroll in our program, intakes are offered free-of-charge and are strongly encouraged. This gives us time to meet your child and for you to meet us.

Deposits

A deposit of $105, which will be applied to the child's last week in the program, should accompany the application for placement. If you apply to the program and we find a placement for your child but then you decide to not accept the placement for therapy, $50 from the deposit will not be refunded. If we are not able to place your child, the deposit will be refunded.

Training Program

Social Thinking Boston is an International Training Center. It 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 coach if you have any questions. Signs will be posted each week we have trainees visiting.

Clinical Therapy 2018-2019

Please make sure all forms are completed and signed prior to submission. Include this checklist with your application packet.

New Clients

- ☐ Application Form
- ☐ Parent Assessment
- ☐ A brief letter from you describing your student (see the Parent Assessment form for letter guidelines)
- ☐ Teacher Questionnaire
- ☐ Video and Audio Permission
- ☐ Outing/Allergy Form
- ☐ Exchange of Information
- ☐ Policies and Procedures
- ☐ IEP/Reports/Outside assessments/any other information which will give us a better understanding of your child and his/her strengths and challenges
- ☐ A recent picture of your child
- ☐ $105 deposit payable to Social Thinking Boston (will be applied to your child's last session in the program)

Returning Clients

Please note that although you may have completed this information in the past, the forms listed below must be completed each term. We only need information such as IEP reports and outside assessments if these have been updated since you last submitted them. Thank you for your help in keeping our records up to date as well as helping us to place your student in the most appropriate group.

- ☐ Application Form
- ☐ Teacher Questionnaire (optional)
- ☐ Video and Audio Permission
- ☐ Outing/Allergy Form
- ☐ Exchange of Information
- ☐ Policies and Procedures
- ☐ Any new information you feel will be relevant to your child's program
- ☐ $105 deposit payable to Social Thinking Boston (will be applied to your child's last session in the program)

Client Information

Please return this application with your $105 deposit.

Date	
Client Name	Birth Date
	Grade (as of Fall 2018)
Parent Name	Parent Name
Address	Address
City/State/Zip Code	City/State/Zip Code
Home Phone	Home Phone
Cell Phone	Cell Phone
Work Phone	Work Phone
Email	Email

Siblings

Name and Age	Name and Age
Name and Age	Name and Age

School Name

District/City

Current Services

□ OT □ Speech □ Resource □ 1-1 Aide □ SDC Class □ Other:

When was your last IEP?

Triennial Testing? (Every 3 years)

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Telephone 978-610-6603 ● www.socialthinkingboston.com ● Fax: 978-610-6604

Scheduling

After-school sessions will be scheduled at 4:00 P.M., 5:00 P.M., and 6:00 P.M., Monday through Thursday. Saturday sessions will be scheduled 9:00 A.M. through 12:00 P.M.
Please use the following system to fill in every square on the schedule

- Write a "0" if your child can absolutely not attend during that time.
- Write a "1" if you would like this is an optimal time.
- Write a "2" if this time is possible but not optimal.

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. If your schedule changes and you are not availiable during the time you originally marked, there is a chance that we may not be able to place your child in the program. Those who do not make it into one of the initial groups will be placed on the waiting list and contacted when an opening occurs. We are generally able to place the majority of applicants in groups.

	Monday	Tuesday	Wednesday	Thursday	Saturday
9:00 A.M.					
10:00 A.M.					
11:00 A.M.					
12:00 P.M.					
1:00 P.M.					
4:00 P.M.					
5:00 P.M.					
6:00 P.M.					

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Parent Questions

Academics

What are your current concerns about your child's performance at school?

What are your current concerns about your child's performance at home?

Please list the classes or topics your child does **best** at school in.

Please list the classes or topics your child struggles the most with.

What are his/her least favorite classes?

Please write a brief letter describing your child. If you are a returning client, only include a letter if there are changes you would like us to keep in mind.
Include the following areas in your letter:

- Your child's strengths and challenges related to functioning in the social world
- His/her interactions with peers
- His/her awareness of their challenges (e.g., Are they aware of how others perceive them; do they think that they are perceived as "different" from their peers?)
- How well he/she understands that his/her actions and words affect others
- How he/she responds to everyday problems, such as changes in the schedule, peer conflicts, etc.

Behaviors

Please check behaviors that describe your child.

- ☐ Motivated
- ☐ Impulsive / Distracted
- ☐ Rigid ("my way or the highway" attitude)
- ☐ Verbally aggressive to peers or adults
- ☐ Anxious
- ☐ Oppositional
- ☐ Physically aggressive
- ☐ Externally distracted
- ☐ Aloof – internally
- ☐ Withdrawn (may hide or shut down when upset)

Please rate your child on a 1-5 scale, with 1 being the worst and 5 being the best.

Paying attention to others		Understanding personal space	
Asking questions about others		Participating in a group	
Making eye contact		Accurately identifying facial expressions	
Understanding the feelings of others		Accurately identifying body language	
Showing empathy		Greeting others	
Listening		Participating in a conversation	
Understanding what people mean by what they say		Quantity of information provided	
Doing homework		Adding relevant comments to a conversation	
Turning in homework		Apologizing	
Keeping backpack organized		Asking for help	
Keeping school desk organized		Personal problem solving	
Taking responsibility for self		Compromising and/or negotiating	
Understanding consequences		Doing chores	

How did you hear about Social Thinking?

□ A provider (counselor, psychologist, doctor, etc.) □ Website/web search

□ Family/friend □ Michelle Winner conference

□ Other _____

Professional Questionnaire

Parents, please have as many educators as possible fill this out

Dear Professional,

Date _____

Name of Student _____

is either being considered for placement in a group or seeking an evaluation at our clinic. It will be of great benefit to have you complete the below information regarding this student based on your own experience.

Please return this form to the person who gave it to you or fax it to our office at the above number. Please have the form completed by

Your name _____

Grade of student _____

Relationship to the student _____

Please check off where you feel how this person does in your setting in the following areas:

Skill to explore	Comments	Above grade level	At grade level	Below grade level	Not observed
Math					
Reading					
Written expression					
Participating as part of the large group during class discussion/lecture time					
Participating as part of a small workgroup					
Making or keeping friends during free time					
Asking for help					
Organizational skills in class					
Organizational skills from home to school					

Does this child stand out as unique in his interpersonal skills, either in class of out of class?	Yes / No, if yes, please explain:
Do you anticipate that this student will encounter more challenges in future school years?	
How would this student's peers describe him/her?	

Any further comments: _____

Video and Audio Permission

Permission to use video or pictured image and audio recording

This form must be signed in order for you/your child to participate in the program!

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

Please check the first two boxes to indicate that you will allow these recordings and wish to participate in our program:

- ☐ I give my child permission for Social Thinking Boston to use the image of me or my child within the clinic setting for therapeutic purposes
- ☐ I give my permission to audio tape me or my child for clinical purposes

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.

Check 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.

Outing Permission

I give permission for my child, _____
to walk in the community, use public transportation, and be transported by vehicle as needed during therapy sessions with a professional employed by Social Thinking Boston.

_____

Parent / Guardian Signature Date (permission for 1 year)

_____

Contact telephone number

Please list any food allergies or dietary restrictions of your child:

_____

_____

_____

_____

Exchange of Information

Your signature is required on this form.

Parent / Guardian Signature	Print Parent / Guardian Name
Print Client Name	Date
Daytime Telephone ○ Home ○ Cell	Alternate Telephone ○ Home ○ Cell

I give permission for any employee of Social Thinking Boston to share information with any of the following people regarding the educational or medical treatment of my child.

Print Professional's Name	Title
Telephone	Email

Print Professional's Name	Title
Telephone	Email

Print Professional's Name	Title
Telephone	Email

☐ **Please contact me prior to contacting any professionals.**

Signature	Date

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Emergency Information

Emergency Contact

Print Emergency Contact Name Phone

Relationship to Client

People permitted to pick up your child

1.

Print Name Phone

2.

Print Name Phone

3.

Print Name Phone

Clinic Policies

Please read, initial, and return with the application packet.

Date _____

I agree to follow the fee schedule and policies as noted.

_____
(Print your child's name)

Please initial every section.

_____ **Absences and missed sessions:**

Group work is dependent on all group members attending sessions regularly. Your group will be most effective when everyone attends consistently as this allows group members to build rapport. Group members must make every effort to attend on a weekly basis. Our clinic calendar details specific holiday closures. Semesters run from early September through mid-January and mid-January through mid-June. **Group members are allowed one excused absence per semester without being charged**. Beyond that, missed sessions will be billed as regular sessions. We require a two week notice if your child is withdrawing from their group.

_____ **Reduced group attendance:**

On the rare occasion that everyone is absent from the group except for one client, we will still hold the session. This is a good opportunity for the child and therapist to focus on individual needs as 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 other group members are out, this will count as your excused absence for the semester or will be billed as a missed session if you have exceeded the allowable absences. Parents are welcome to attend this private session as well.

_____ **Siblings in the waiting room:**

Parents of children younger than 13 years old should stay in or very near the clinic during the session. If on any particular day if you feel your child is agitated or becomes easily agitated, please do NOT leave the clinic.

If you are bringing a sibling to the clinic, please bring some books or small toys for the sibling to play with. We have a small selection of books available as well as a table where siblings can do homework, etc. We expect siblings to maintain a reasonable level of calm and quiet during their time waiting. If they need to move around please walk them down the block, however, make sure we have your cell phone number in case we need to call you. Please do not leave your children unsupervised in the waiting room at any time. Ensuring your children are following the waiting room expectations helps to create a comfortable environment for all.

_____ **Late child pickup:**

In the event that a child is not picked up at the end of the session, we reserve the right to charge a $100.00 fee for any part of each half-hour that they are left waiting (e.g. 40 minutes late, $200). We realize this may seem extreme, but as you know, many of our students do not deal well with stress and/or transition. As the professional must start her next group on time and cannot stay with your child, this provides a very difficult situation for our staff. We have adopted this policy in order to keep our

clinical schedule running smoothly and allow our staff to devote their time to our students.

☐ **Observation of sessions:**

Observations of therapy sessions are very limited. We have a number of groups conducting therapy in close proximity to observation areas and must maintain everyone's privacy. Any observation, if allowed, is completely at the discretion of the clinic and must be arranged prior to the session date.

☐ **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 parents/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. 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 extra administrative requests which include copies of previous invoices, reports, therapy handouts, etc. 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. We request that all families who plan to file an insurance claim for our clinic's work contact us to let us know their intentions.

3. Some insurance companies will only reimburse for specific Diagnostic Codes. We obtain the diagnostic code from the information in the client's file. This code is only assigned based on a medical diagnosis (as opposed to an educational classification). We are unable to make changes to the diagnostic code without a written medical diagnosis from a qualified professional. For any client that does not have a medical diagnosis on file we will use a non-medical insurance code. We are also unable to change this code to reflect a service other then what was given (such as indicating a session was an individual session rather then a group session). We recognize that some insurance companies are willing to cover some services and not others (for example, individual sessions but not group sessions), but legally we are unable to indicate that we provided a service that we did not.

4. Even if families are the ones filing the claim, the insurance company will still come to us for information about our services and will want to see copies of group therapy notes for insurance coding. We then have to "black out" information about all other clients mentioned in the week's notes. Thus, parents filing claims from their home still involve our clinic's administrative staff.

5. We will not sign any contract offered to us by an insurance company that states that we agree to pay a lesser fee than what we have established as our fee for service, even if the parent has paid our insurance administrative fee.

Billing:

For your convenience, we offer two options of payment. Please choose one:

☐ **Monthly**: Invoices are issued at the beginning of each month for the following month's therapy sessions. Payment is due prior to the start of that month's sessions.

☐ **Semester**: Invoices are issued the week prior to the start of the semester and is due by the first session of the semester.

Credit card number Expiration date

We **require** a credit card number. It will be charged if payment is not received by the first session of the month.

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

☐ This initial indicates that you have read/received a copy of the Social Thinking Privacy Policy. (Please make a copy for your file)

Parent / Guardian Signature Date

Print Parent / Guardian Name Print Student's Name

Services & Fees

Therapy sessions:

- Kindergarten through Adult
  - $105 per 60-minute session when 3 – 4 students are in the group
  - $125 per 60-minute session when 2 students are in the group
  - $200 per 60-minute individual session
  - $300 per 60-minute individual session with a psychologist
  - $250 per 60-minute session for off-site services
- Early Social Learning
  - $135 per 90 minutes for group sessions
  - $155 for individual sessions
- Evaluations
  - $1500 including report
- Additional Consultation
  - $200 per hour for:
    - Consultation with parents
    - Report writing
    - IEP attendance (travel time is billed as well)
    - Phone calls exceeding 10 minutes with a professional

Please retain this copy for your files.

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Privacy Policy

It is important that you review this information, initial the box on the policies signature page and keep it 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 Boston (STB) to perform **Treatment**, **Acquire Payment,** and perform **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**: STB 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 professional will speak openly to all the parents about all the students in the group with regard to their participation and things they need to work on at home. The professional 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.
  - STB 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 STB 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 Professional 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 STB Privacy Policy.
- All Staff will exert due diligence to avoid being overheard when discussing PHI.
- All records will be maintained in a secure environment.

Grievances

- Clients who have complaints or concerns with regard to therapeutic management, please first contact your child's personal professional to discuss your concern. If you feel that she has not been able to adequately address your needs, then please contact the Director. For all other questions, concerns or complaints please address them to the STB Office Manager. If the office manager cannot handle them directly, she will bring them to the attention of the relevant employee at the STB. 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 Boston will not retaliate against any individual for filing a complaint.

Administration

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

Additional Resources on Health Information Privacy

- Health Privacy Project
  Georgetown University
  www.healthprivacy.org
- Office for Civil Rights
  U.S. Department of Health & Human Services
  www.hhs.gov/ocr/hipaa/

Please retain this copy for your files.