CIT SUMMER LEARNING EXPERIENCE at STB

This is a motivational pathway for teens to explore the ever-changing social expectations of the workplace and have practice being part of a small team with like-minded peers.

The CIT program is run by director, Nancy Clements, who brings years of expertise and deep insight into helping teens strategically build their social competencies. The program allows teens to have a coached job experience while providing multiple opportunities to interact, work and hang out with peers.

The program is designed for teens who have had a robust introduction to Social Thinking and are ready to "practice what they know" in a coached setting. Space is limited to 4 students per session. Due to the demand of the program and limited availability, interested participants are encouraged to inquire early.

Highlights	Sample Activities
• Program coached by Nancy Clements • Small groups matched by age and social level • Daily goal setting and wrap-up • Goals and activities are focused around Social Thinking frameworks and concepts • Opportunities to be role models in a coached setting • Stipend for week of work • Opportunity to obtain interview experience • Weekly parent wrap-up	• Group planning meetings • Coached job practice • Creating activities and overseeing cooking projects • Problem solving as related to executive functioning • Practice work in small groups and collaboration with peers • Community performance and outing trips • Hang out time with peers

Dates & Pricing

DATE	TIME	PRICE
July 22 to 25	9:00 to 3:00	$1,375
July 29 to Aug 1	9:00 to 3:00	$1,375
Aug 5 to 8	9:00 to 3:00	$1,375

For more information regarding which weeks best fit your child, please contact Jill Day at jday@socialthinkingboston.com or call (978) 610-6603.

CIT Registration Form 2019

Session Dates Please Check

__ July 22 to 25 9:00 to 3:00
__ July 29 to Aug 1 9:00 to 3:00
__ Aug 5 to 8 9:00 to 3:00

Client Name: _____ Birth Date: ___/___/___

Client Age: _____ Grade: (As of Fall 2019) _____

Client Gender: _____ School: _____

Parent Name: _____ Parent Name: _____

Address: _____ Address: _____
_____ _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

Email: _____ Email: _____

Emergency Contact Information

Name: _____
Relationship: _____
Phone: _____
Can this person pick up your child? Yes/ NO

Please list any food allergies or diet restrictions for your child: Child needs Epi-Pen? __YES __NO
* EPI Pen must be provided daily

See the brochure for pricing information. **A non-refundable** deposit of 50% of the session cost is required in order to process each child's application. Final (non-refundable) payment is due May 31.

Signature of parent/ guardian _____
Date _____
Total Amount enclosed _____
Credit Card _____
Expiration date _____

*We **require** a credit card to be placed on file. It will be charged if payment is not received by May 31.

OUTING PERMISSION

☐ I give permission for my child, _____ to walk in the Community and/or use public transportation or be transported as needed throughout the program with a professional employed by Social Thinking Boston.

_____ _____
Parent Signature Date

_____ _____
Contact Telephone Number Alternate Contact Telephone Number

RESEARCH PERMISSION

☐ I give Social Thinking Boston permission to provide services to my child and understand that any data that is used for research purposed will be done anonymously.

_____ _____
Parent Signature Date

PERMISSION TO SHOW YOUR CHILD IN PICTURE OR VIDEO

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 note that these recordings will **only** be used for our own purposes and will not be shared with any third parties.

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

☐ I give permission for Social Thinking Boston to use the image of me/my child within the clinic setting for therapeutic purposes.

☐ I give permission for Social Thinking Boston to audiotape me/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 or my child to be used in both clinical and conference settings.

Print parent/guardian name

Parent/guardian signature

Print child's name

Date

EXCHANGE OF INFORMATION

Your signature is required on this form.

Student's name

_____

Parent/Guardian's name

_____

Address

_____

Daytime Telephone (circle one: home / cell)

_____

Alternate Telephone (circle one: 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 for my child.

_____

Professional's Name – Print clearly

_____

Title

_____

Telephone

Email

_____

Professional's Name – Print clearly

_____

Title

_____

Telephone

Email

☐ **PLEASE CONTACT ME PRIOR TO CONTACTING ANY PROFESSIONALS.**

_____ ____/____/____

Signature Date:

CLINIC POLICIES

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

PAYMENT FOR THE SUMMER SESSION IS DUE IN FULL ON OR BEFORE THE FIRST DAY OF SESSIONS.

Please initial <u>every</u> section.

____ **<u>Absences and Missed Sessions:</u>**

There are no excused absences in the summer. Clients planning vacations must understand that by signing up for a summer session you are committing to pay for the entire session even if you are not able to attend all of the sessions.

____ **<u>Sick Child Policy:</u>**

Children who are showing signs of illness or lethargy do not benefit from attending therapy sessions. Please exercise good judgment in deciding whether or not to bring your child to the clinic. If they are running a fever, are lethargic or complaining of illness, please keep your child at home.

____ **<u>Policy for late child pickup:</u>**

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. Additionally, the therapist must start her next group on time and cannot stay with your child, which creates 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.

____ **<u>Recordings for therapeutic purposes:</u>**

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 your child to participate in our program. Recordings will only be used within the group or individual session, not to be viewed by the public

____ **<u>Use of email to communicate Protected Health Information:</u>**

Periodically we use email to relate client-specific information, information that is Protected Health Information (PHI), directly to adult clients or to the parents of minor-aged clients. Please see the attached Privacy Policy for information about PHI. Your initials here authorize our therapists to communicate client PHI to you via email. Note: Email addresses will not be sold or shared with any other parties or services.

____ **<u>Policy for processing insurance claims or other administrative tasks</u>**:

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 ICD-10 Diagnostic Codes. On your monthly billing statement, we include the diagnostic code from 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, ICD-10: R69 Unspecified diagnosis (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.

____ **<u>Payment Policy:</u>**

Payment for the summer session is due in full by **May 31, 2018.** Payment in full is the responsibility of the client, whether or not you are waiting for insurance reimbursement. There is a $25.00 charge for returned checks. If you have any questions or need to arrange a payment plan, please contact Liz Shron at (978) 621-6895 or by email elshron@socialthinkingboston.com.

____ **<u>Privacy Policy:</u>**

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.

Please sign to indicate that you have read and agree with our Clinic Policies.

_____ _____

Parent Signature Date

_____

Print parent/guardian name

PRIVACY POLICY

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 STUDENTS 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 contractor 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 personal therapist 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 ST Office Manager. If the office manager cannot handle them directly, she will bring them to the attention of the relevant employee at 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 ST 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 sign below indicating you have read and understood these privacy policies.

_____ _____
Parent Signature Date

_____
Print parent/guardian name

PLEASE HAVE YOUR TEEN COMPLETE THE FOLLOWING FORM AND RETURN TO US

Thank you,
The STB Team

CIT Application

Name: _____
Age: _____ Grade: _____
School: _____
Address:_____
_____
Email: _____
Cell Phone: _____

Please answer the following:

What are your hobbies/ things that you like to do?

What is your most favorite class in school and why?

What is your least favorite class in school and why?

Use three words to describe yourself.

Why do you feel are a good fit for this role?