



Autism Services North  
39 Tannery Rd  
Dillsburg, PA 17019  
Phone (717) 961-6895  
Fax (866) 206-8650

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**Consultation****Analysis****Therapy**

Thank you for choosing Autism Services North as your ABA provider. We view our relationship with you as a partnership in your ABA needs. We have prepared the following guidelines in an effort to ensure that we provide healthcare services to you in an efficient manner. Our providers and staff look forward to assisting you with your ABA needs.

- Our office hours are Monday-Friday 8:30am-4:00pm. Should an emergency occur immediately call 911.
- You are responsible for contacting your insurance provider prior to your initial visit.
- Before we start services an "Authorization for Services" (auth) must be on file. If you start services before our office receives the authorization you as the parent will be responsible for those charges.
- Please keep in mind that you are not the only client that your provider may have. Your provider works varied hours to meet your schedule so please be courteous and ensure that all appointments are kept. If you can not keep your appointment please give your provider 24 hours notice.
- Co-pays are paid directly to your provider.

Please review and complete the attached forms and return them to our office within the next 10 days. Completion of these forms is necessary because of treatment needs, laws and governmental regulations.

Sign and return these forms:

- **Authorization for Release of Protected Health Information**
- **CMS 1500**: Autism Services North will submit your claims if the CMS 1500 form is completed. If not, you will be responsible to submit your own claims. *Please be sure to sign both lines 12 & 13.*
- **Insurance Update & HIPAA Notice**:

Again, we look forward to assisting you with your ABA needs. If you have any questions or concerns, please feel free to contact our staff at 717-961-6895.

Sincerely,

Autism Services North

6/09

# Authorization for Use or Disclosure of Protected Health Information

Name of Service Recipient: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize the use and disclosure of my health information as indicated below. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

I hereby authorize the release of the information checked and/or listed below for the time period beginning on January 1, 2009 and ending on January 1, 2010:

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Complete health care record(s)    | <input checked="" type="checkbox"/> Discharge Summary                          |
| <input type="checkbox"/> History & Physical Examination               | <input checked="" type="checkbox"/> Progress Notes                             |
| <input type="checkbox"/> Minimum Data Set                             | <input checked="" type="checkbox"/> Treatment/Care Plans                       |
| <input checked="" type="checkbox"/> Laboratory Reports                | <input type="checkbox"/> Dental Records  |
| <input checked="" type="checkbox"/> Medical / Treatment Records       | <input type="checkbox"/> Photographs, Video Tapes, Digital,<br>or other images |
| <input checked="" type="checkbox"/> Pathology Reports                 | <input checked="" type="checkbox"/> Billing Statements                         |
| <input type="checkbox"/> X-Ray Reports                                | <input type="checkbox"/> Emergency Care Records                                |
| <input type="checkbox"/> Transcribed Reports                          | <input checked="" type="checkbox"/> Consultant Reports                         |
| <input type="checkbox"/> Nurses' Notes                                |  |
| <input checked="" type="checkbox"/> Psychiatric/Psychological Reports |  |
| <input checked="" type="checkbox"/> Other: <u>IEP</u>                 |  |
| Other: _____  |  |

X The information checked and/or listed above is to be released to: Tricare/ ECHO – Autism Services North, EFMP and school system as needed

X The information checked and/or listed above is to be obtained from: Tricare/ ECHO-Autism Services North, EFMP and school system as needed  
for the purpose(s) of collaboration of services and discussion of treatment progress.

Unless otherwise revoked by me, I understand that this authorization will expire on January 1, 2010 or upon the completion of the use of the information for the purpose it was intended, whichever is earlier.

I hereby authorize the above information to be X mailed, X faxed, and/or X emailed.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services.

I hereby release the agency, its employees, officers, and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I may revoke this request at anytime by providing the agency with my written notice of such revocation.

Date: \_\_\_\_\_ Signature of Service Recipient (if over the age of 14): \_\_\_\_\_  
Printed Name of Service Recipient: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Representative/Guardian: \_\_\_\_\_  
Printed Name of Representative/Guardian: \_\_\_\_\_  
Relationship to Service Recipient: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Witness: \_\_\_\_\_  
Printed Name of Witness: \_\_\_\_\_

A copy of this record must be provided to the person making the request and a copy must be filed in the medical record.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA [ ] [ ] [ ] PICA [ ] [ ] [ ]

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code) ( )		CITY STATE	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.			

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____	
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14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
19. RESERVED FOR LOCAL USE		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	

	A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EP/SDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From MM DD YY	To MM DD YY			CPT/HCPCS	MODIFIER						
1												NPI
2												NPI
3												NPI
4												NPI
5												NPI
6												NPI

25. FEDERAL TAX I.D. NUMBER SSN-EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  SIGNED _____ DATE _____				32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____				33. BILLING PROVIDER INFO & PH # ( ) a. _____ b. _____			

CARRIER ↑ PATIENT AND INSURED INFORMATION ↓ PHYSICIAN OR SUPPLIER INFORMATION ↓

**AUTISM SERVICES NORTH  
INSURANCE UPDATE & HIPAA NOTICE**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I request that payment of authorized benefits be made directly to Autism Services North. I understand that I am financially responsible for charges not covered by the authorization of this form.

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Signature of Patient/Parent \_\_\_\_\_

Date: \_\_\_\_\_

**HIPPA INFORMATION RECEIVED** *(HIPPA info below)*

Signature of Patient/Parent \_\_\_\_\_

Date \_\_\_\_\_

# HIPPA

## Autism Services North Explanation of Privacy Practices

Autism Services North all of its employees, staff and other personnel is committed to protecting medical/behavioral/educational information about you. All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or operation purposes described in this notice.

This notice, in compliance with federal privacy regulations, describes how information about you may be used and disclosed and how you can get access to this information. In cases where state law is more restrictive than the federal privacy regulations, Autism Services North will comply with state law. Please review this carefully.

### **Understand Your Health Record/Information**

Each time you are treated at the hospital or by a physician or other healthcare provider, a record of your treatment is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information is referred to as your health or medical record.

### **Your Health Information Rights**

Although your health record is the private property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record
- Request an amendment to your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

### **Our Responsibilities**

Autism Services North will:

- Maintain the privacy of your behavioral/medical health and educational information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

You do not need to return this page

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We reserve the right to change our practices and to make the new provisions effective for all protected behavioral health/medical and educational information we maintain. Should our information practices change, notification will be provided.

The following categories describe different ways that we use and disclose medical information based on your consent. For each category of uses or we will explain and try to give some examples. Not every use or disclosure in every category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

**For treatment:** We may use behavioral health/medical and educational information about you to provide you with behavioral health/medical and educational treatment or services. We may disclose medical information about you to doctors, nurses, technicians, clinical students, or other healthcare personnel who are involved in your care within Autism Services North.

For example, a BCBA treating you with staying on task may need to discuss this information with your PCM for medication management.

**For payment:** We may use and disclose behavioral health/medical and educational information about you so that the treatment and services you received at Autism Services North may be billed, and payment may be collected from you, an insurance company or a third party. For example we may need to give your health plan information about behavioral treatment plans, progress reports, etc. so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.

**For Health Care Operations:** We may use and disclose behavioral health/medical and educational information about you for Autism Services North operational reasons. These uses and disclosures are necessary to run Autism Services North and make sure that all of our clients receive quality care. For example, we may use and disclose medical information to review our treatment and services and to evaluate the performance of our staff in caring for you, or to accrediting agencies that evaluate current services, decide what additional services Autism Services North should offer, and whether certain new treatments are effective. We may also disclose information to clinical students, staff, and other Autism Services North personnel for review and learning purposes. We may also disclose information to business associates who provide contracted services such as accounting, legal representation, claims processing, accreditation, and consulting. If we do so, we will do so subject to a contract that provides that the information will be kept confidential.

**Appointment Reminders:** We may use and disclose behavioral health/medical and educational information to contact you as a reminder that you have an appointment for treatment or medical care.

You do not need to return this page

**Treatment Alternatives:** We may use and disclose behavioral health/medical and educational information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**As Required by Law:** We will disclose behavioral health/medical and educational information about you when required to do so by federal, state, or local law.

**To Avert a Serious Threat to Health or Safety:** We may use and disclose behavioral health/medical and educational information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone who is handling the situation.

**Sale or merger:** If Autism Services North at any time sells or merges any of its entities with another health system, the new owner may have access or acquire records associated with that entity.

**Special Situations:**

- Military and Veterans- information may be released to military command authorities.
- Public Health Risk-information may be released to public agencies to prevent or control disease, report abuse or neglect.
- Lawsuits and Disputes- information may be released in response to a court or administrative order, subpoena, discovery request or other lawful process.