Welcome to Alpine Autism Center. We look forward to working with you, your family, school, and other service providers in developing a successful program.

Alpine Autism Center is a nonprofit organization whose mission is to provide access to effective treatment for individuals and families affected by autism in the Pikes Peak Region, enabling those affected by autism to reach their full potential.

This application packet must be completed and submitted prior to the start of your child's program. The following checklist outlines the contents of the application packet:

_____**Patient Registration Form**
Please fill out completely and include a current picture of your child.

Please fill out the following in their entirety:
_____**Medical Release and Emergency Contact Form**
_____**Health/Service Provider Contact Information**
_____**Family Questionnaire**
Complete this form carefully. It will become a permanent part of your child's medical record. Any information recorded is strictly confidential. Please make a photocopy for your records.
_____**Developmental Goals**
_____**Behavior Questionnaire**
_____**Diet Form**

_____**General Health Appraisal**
This form must be completed and signed by your child's pediatrician.

_____**Certificate of Immunization**
Please have your physician fill out and sign the provided form. For processing reasons, alternative immunization forms are not sufficient substitutes for the provided form.

Please sign:
_____**Acknowledgement of Receipt Privacy Practices**
_____**Acknowledgement of Receipt Parent Handbook**
Located in the Parent Handbook
_____**Acknowledgement of Receipt of Attendance and Payment Policy**
_____**Confidentiality Policy**
_____**Consent for Treatment**
_____**Consent for Administration of Medication**
_____**Medical Emergency Treatment and Transportation Release**
_____**Media Release**
_____**Persons to Release**
_____**Consent to Request/Release Medical Information**
_____**E-Mail Consent to Communicate with Health Care Providers**
_____**TV/Video Permission**

Insurance
At this time, the Alpine Autism Center is only able to bill the following payor sources: Tricare and Medicaid CES waiver.

Payment
Payment is due at time of service. We accept checks or credit cards (Visa or Mastercard).

PATIENT REGISTRATION FORM

Date _____

Patient Full Legal Name (Last, First, MI): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Social Security Number: _____- _____ -_____

Diagnosis: _____

Other Conditions: _____

Mother / Legal Guardian: _____

Relationship: (please check)

Biological _____ Adoptive_____ Step _____ Foster _____

Address: _____

Home Phone ( ) _____ Work Phone: ( ) _____ Cell: ( ) _____

Email: _____

Father/ Legal Guardian: _____

Relationship: (please check)

Biological _____ Adoptive_____ Step _____ Foster _____

Address: _____

Home Phone ( ) _____ Work Phone: ( ) _____ Cell: ( ) _____

Email: _____

Patient's Siblings

Name: _____ Age: _____ Gender: _____

Name: _____ Age: _____ Gender: _____

Name: _____ Age: _____ Gender: _____

Name: _____ Age: _____ Gender: _____

Patient's primary care physician:

Name: _____ Clinic/Company practice: _____

Address: _____

Phone: ( ) _____ Fax: ( ) _____

Email: _____

Third Party Billing Information

Insurance Company: _____

Address: _____ Phone Number: _____

Policy Holder: _____

Policy Number: _____

Physical Description (please attach a current picture)

_____

_____

_____

_____

_____

Medical Release and Emergency Contact Form

Client _____DOB_____

Address _____

Parent/Legal Guardian_____

Home #_____ Work #_____ Cell # _____

Other Parent or Legal Guardian _____

Home #_____ Work #_____ Cell # _____

Emergency Contacts (other than parents**) Must list 3** (1 local):

1. Name_____Phone_____

   Address_____Relationship_____

2. Name_____Phone_____

   Address_____Relationship_____

3. Name_____Phone_____

   Address_____Relationship_____

Disability/Diagnosis_____

Allergies (Food/Other)_____

Seizures Y N Type/Description_____

Medication and Supplements/Dosages/Time Given (attach separate listing if necessary, include all vitamins, supplements, enzymes, etc.):

1._____

2._____

Any medical special needs for the Alpine Autism Center to be aware of:

_____

Health/Service Provider Contact Information

Pediatrician or Family Practitioner

Name: _____

Phone Number: _____

Speech Therapist

Name: _____

Phone Number: _____

Physical/Occupational Therapist

Name: _____

Phone Number: _____

Neurologist

Name: _____

Phone Number: _____

Preferred Hospital

Name: _____

Phone Number: _____

Dentist

Name: _____

Phone number: _____

Psychologist

Name: _____

Phone Number: _____

Other

Name: _____

Specialty: _____

Phone Number: _____

FAMILY QUESTIONNAIRE

Patient Name: _____ **Date: _____**

PART I – CONCERNS & STRENGTHS

What specific concerns do you have about your child?

_____

_____

_____

_____

When did you first develop these concerns?

_____

_____

_____

_____

Whom have you seen previously about your concerns and what were you told about your child?

_____

_____

_____

_____

What are your child's interests and strengths? What does he/she like to do?

_____

_____

_____

_____

What are your child's likes and dislikes?

_____

_____

_____

_____

What questions would you like answered during the evaluation?

_____

_____

_____

What agency or individual referred you here for evaluation?

Name: _____ Phone: _____

Address: _____

_____

PART II – FAMILY HISTORY

Is there any history of the following on either side of child's biologic parents' families? If yes, indicate with an "X" on FATHER'S or MOTHER'S side and explain who (grandmother, etc.) in last section.

#	DESCRIPTION	NO	YES	FATHER'S	MOTHER'S	WHO?
1	Psychological/Emotional					
2	Mental Retardation					
3	Learning Disabilities					
4	Birth Defects					
5	Seizures/Convulsions					
6	Tuberculosis					
7	Neurological Disease					
8	Diabetes					
9	Cancer					
10	Allergies/Asthma					
11	Gland Disorder/Thyroid					
12	Hearing Impairments					
13	Vision Impairments					
14	Hyperactivity					
15	Miscarriages					
16	Slow Development					
17	Autism					
18	Fragile X					
19	Speech Problems					
20	Other ---					

Comments: Explain conditions present on either side of family. (i.e. Specific conditions, etc)

_____

_____

PART III – PREGNANCY & BIRTH HISTORY

Please list all pregnancies and miscarriages of child's biological mother, in chronological order.

Birth Date	Birth Weight	Health or Developmental Description

Please describe anything unusual or exceptional about the pregnancy and/or birth of the child being evaluated:

_____

_____

_____

_____

Was baby born early, late or on time? (circle) # of weeks? _____

Was baby born by normal vertex (head down), breech or c-section?

Baby's birth weight _____ and length _____.

Apgar score? _____

Are biologic parents related by blood? Yes No How?

_____

Please check the following if present during pregnancy or birth:

Excessive bleeding	Fever	Rash
Prescription Drugs	Toxemia	Poor weight gain
Illicit/street drugs	Cigarettes	Narcotics
Alcohol	Supplemental oxygen	Illnesses

Please check the following if present during newborn period:

Jaundice	Feeding difficulties	Suspicion of infection
Poor temperature control	Poor activity	Other?

PART IV – DEVELOPMENTAL HISTORY

DEVELOPMENTAL MILESTONES: Write down the age when your child first did each of the following. Write "no" if your child has not yet done it. If you do not remember, please leave it blank.

Smiled		Held head erect		Separated easily from mother	
Imitated sounds		Rolled over		Ate unaided with spoon	
Said "mama" or "dada"		Sat alone		Knew Colors	
Said other single words		Crawled		Started counting	
Followed simple directions		Walked alone		Recited total alphabet	
Said 2-3 word phrases		Rode tricycle		Read Words	

In general, did you feel your child developed quickly, typically or slowly?

_____

_____

_____

_____

TEMPERAMENT: Please comment on the following behaviors for you child as an infant and as a toddler:

How active is your child?
How well does your child deal with transition and change?
How well does your child respond to new places, people and things?
What is your child's basic mood? Happy? Sad? Angry? Quiet? Other, please explain?
Is your child predicable in patterns of sleep, appetite, etc.?

PART V – CLIENT'S MEDICAL HISTORY

Please indicate if the following are relevant currently or in the past. A brief explanation is helpful.

#	DESCRIPTION	NO	YES	EXPLANATION
1	Abdominal pain/bowel issues			
2	Allergies			
3	Anemia			
4	Birth Defects			
5	Concussion/head injury			
6	Dental problems			
7	Drooling			
8	Ear infections			
9	Eating issues/gags/chokes			
10	Headaches			
11	Hearing loss			
12	Heart condition			
13	Blood disorders			
14	Hormone problems			
15	Ingestion poisons			
16	Joint or bone problems			
17	Lung or breathing problems			
18	Muscular problems			
19	Seizures or convulsions			
20	Significant accidents			
21	Skin disease			
22	Tics or repetitive movements			
23	Urinary problems/infections			
24	Visual/eye problems			
25	Other medical concerns			

Hospitalizations: List any hospitalizations, operations of child:

_____

_____

_____

_____

Medications: List medication (s) child currently takes:

_____

_____

_____

_____

Current weight: _____ Current height: _____

Are your child's immunizations up to date? Yes _____ No _____

(Please provide a copy the current immunization records or a signed exemption form.)

#	DESCRIPTION	NO	YES	EXPLANATION
1	Difficulty toilet training			
2	Temper tantrums			
3	Breath holding			
4	Destructiveness			
5	Disobedience			
6	Sleep problems			
7	Bedwetting			
8	Masturbation			
9	Nail biting			
10	Thumb sucking			
11	Self- injurious behavior (e.g. head banging)			
12	Unusual Fear			
13	Poor concentration			
14	Distractibility			
15	Aggression			
16	Eating problems			
17	Cruelty to animals			
18	Mood swings			
19	Hair pulling			

Any other behavior issues you would like to mention or explain:

_____

_____

_____

_____

Does your child:

#	DESCRIPTION	NO	YES	EXPLANATION
1	Get along with other children			
2	Become easily upset or frustrated			
3	Become angry or destructive easily			
4	Become overactive			
5	Prefer to be alone			
6	Misbehave frequently			
7	Have difficulty sitting still			
8	Have any problem with awkwardness or clumsiness			
9	Listen well			
10	Follow spoken directions			

How do you discipline your child? Please give an example.

_____

_____

_____

_____

PART VI – EDUCATIONAL PROFILE

Please indicate schools attended in chronological order.

School Name and Level	Date Attended

Has your child ever received special education services? Please explain.

_____

_____

_____

_____

Describe any current school programs.

_____

_____

_____

_____

Has your child ever received any developmental evaluation or testing in the past?

_____

_____

_____

_____

DEVELOPMENTAL GOALS

Please tell us what you consider to be important goals for your child in the following areas:

Communication:

_____
_____
_____
_____
_____

Social Skills and Relationship Development:

_____
_____
_____
_____
_____

Sensory Integration and Motor Skills Development:

_____
_____
_____
_____
_____

Structured Learning, Pre- Academics, and Academic Skills:

_____
_____
_____
_____

Our Family

As a family we'd like to be able to…

_____
_____
_____
_____
_____

Places in the community we enjoy are…

_____
_____
_____
_____
_____

Places in the community that are sometimes difficult…

_____
_____
_____
_____
_____
_____

The Alpine Autism Center can help our family by…

_____
_____
_____
_____
_____

If you feel like there is additional information you would like to provide that would help us know you or your child better, please list that information below. We look forward to getting to know your child!

_____
_____

BEHAVIOR QUESTIONNAIRE

Client_____

Parent(s) _____

Date of questionnaire: _____

The behavior analyst should ask the following questions. A yes or no answer is fine. If parent answers "yes" to any of the questions, an Alpine Autism Center behavior analyst will perform a functional behavior assessment to be done after child starts after child starts program.

The original of this form should go to the PC with other child specific registration forms. A copy should go into the front of the child's individual classroom book, and a copy to behavior analyst.

1. Has your child had prior behavior intervention? If so, describe.

2. Has your child ever been aggressive towards others, including biting? If so, describe.

3. Has your child ever destroyed property? If so, describe.

4. Has your child ever injured himself or herself? If so, describe.

5. Has your child ever run away (e.g. bolting)? If so, describe.

6. Does your child take medication? If so, describe purpose and dosage.

7. Does your child have seizures? If so, describe.

DIET FORM

In order to better ensure that we are following through with your child's dietary intervention, we ask that you take a moment and answer these questions concerning his/her dietary modifications.

1. Is your child on a restricted diet?
    a. Yes
    b. No
    If yes, which one(s)?_____

2. What dietary elimination(s) are currently being used (gluten, milk, yeast, soy, corn, eggs, others)?
_____
_____
_____

3. How long has your child been on the diet?
_____
_____

4. Is your child on an elimination and rotation diet?
    a. Yes
    b. No
    If yes, please describe your routine/schedule:
_____
_____

Please provide us with any additional information and/or requests (attach)

Child: _____ Date: _____

Parent/Guardian signature):_____

GENERAL HEALTH APPRAISAL (2-16 years) FOR ENROLLMENT IN ALPINE AUTISM CENTER
(Completed by the Health Care Professional within 2 months of admission)

Name_____Birthdate_____

Date of Exam: _____

Health History & Medical Information (pertinent to routine child care & emergencies):
Description and list of diagnoses _____
_____
_____
_____

Special Diet _____
Allergies _____Type of reaction _____
Current medications _____
Acetaminophen (Tylenol) _____ may be given for fever over 102° or pain every 4 hours as needed
(amount)
Note: No more than a 3 day period, without further medical authorization

Describe any recurrent health problems (such as asthma, seizures, ear infections, diabetes, etc.), illness, hospitalization or concerns with development? Indicate if the child does not have recurrent health problems.
_____

_____

_____

Comments: (include instructions to service provider(s))

_____

_____

Weight _____ Height _____

Vision _____ Hearing _____ Dental Screening _____

Health Provider Name _____

Address _____

Address _____ Phone _____

Health Provider Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF ALPINE AUTISM CENTER PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____ have received a copy of the
Print Full Name

Alpine Autism Center's Notice of Privacy Practices.

_____ _____
Signature of Parent/Guardian Name of Dependent(s)

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Guardian not present for appointment of minor patient; forms sent with patient
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Individual refused to sign
- ❑ Other

ATTENDANCE and PAYMENT POLICY
January 2014-December 2014

In order to better serve our clients and ensure stable staffing and financial viability, the Alpine Autism Center implements the following payment schedule and attendance policies. The fee schedule is based on the annual calendar (attached) and direct costs for clinical staff providing an average of 18 service days per month. The annual calendar is subject to change. All fees will be assessed and invoiced on a monthly basis.

Attendance Hours

Part Time Program:

Morning program: 8:30 a.m. – 11:30 a.m. Monday thru Friday
Afternoon program: 12:30 p.m. – 3:30 p.m. Monday thru Friday

Full Time Program:

8:30 a.m. – 3:30 p.m. Monday thru Friday (full day)

Note: Full time students will receive 6 hours of therapy per day, plus a one hour lunch break (11:30 – 12:30). During the lunch break, the child will receive support/therapy during feeding as necessary. After lunch, the child will be engaged in appropriate leisure activities (reading, computer) until class time resumes at 12:30. Line of site supervision will be provided at all times. This hour is not charged in the fee structure.

Fee Schedules and Payment Options

Because we accept payment from various insurance, Medicaid, public school, and private sources, we offer the choice between one of the two following payment options (see attached spreadsheet):

Tuition Payment:
$2,300 per month Part Time
$4,600 per month Full Time

Per Diem Payment:
$45 per hour for line therapy/general programming
$125 per hour for BCBA or BCaBA supervision

Both payment options require continuous enrollment in either part time or full time programming as outlined in the individual service contract or authorization (usually at least one calendar year).

Payments and Overdue Accounts

Tuition payments are required in advance of service delivery. Tuition charges will be invoiced on or before the last business day of the previous month are due by the 15th of each month. Past due accounts will incur a $50 late fee and shall accrue interest at the rate of 12% per annum until paid. Any payments not received by the end of the month may result in disenrollment from the program.

Per Diem payments are collected in arrears. Per Diem invoices will be issued at the end of each month and payments are due within 30 days. Past due accounts will incur a $50 late fee and shall accrue interest at the rate of 12% per annum until paid. Any payments not received within 60 days may result in disenrollment from the program.

Attendance

In order for appropriate services to be delivered to children with autism, attendance must be structured and consistent. Competent and experienced staff cannot be maintained if fees do not generate stable funding levels. Children absent due to sickness or family needs will not result in a reduced tuition rate for the month. Per Diem charges will not be invoiced if a child is absent due to illness, however, absence due to illness for more than ten service days during the calendar year (January 2014 – December 2014) may result in disenrollment.

Families/clients may utilize up to two weeks of vacation per year during which fees are waived. Vacation credit is only provided in week-long increments, up to two times per calendar year (January 2014 – December 2014). Vacation absences should be coordinated at least two weeks prior to monthly invoicing.

On-time Arrival and Pick-up

Children must arrive on-time and be picked up promptly at the end of session. This ensures appropriate services are delivered and clinician's time is effectively and efficiently utilized. Parents/clients should call the center at 203-6903 if they cannot meet the scheduled arrival or departure times. This will ensure that staff is prepared to receive the child with minimal disruption to the other students who have already started session.

Scheduled arrival time for morning/full day session:
8:25 a.m. – 8:35 a.m.

Scheduled arrival time for afternoon session:
12:25 p.m. – 12:35 p.m.

Scheduled departure/pick-up time for morning session:
11:25 a.m. – 11:35 a.m.

Scheduled departure/pick-up time for afternoon/full day session:
3:25 p.m. – 3:35 p.m.

Unscheduled late pick-ups (after 11:45 p.m. or 3:45 p.m.) may be subject to the after hours care charges outlined below.

Before or After Hours Care

Child care before or after session is available on a case-by-case basis and must be scheduled at least one week in advance. Care is line-of-sight supervision for safety and appropriate behavior (no one-on-one therapy or data collection). Rate is $10 per ½-hour, chargeable only in ½-hour increments.

Program Disenrollment and Schedule Changes

Due to our staffing ratio, we require a 90 day notice for disenrollment and/or changes to a child's schedule in order to provide adequate notice to employees.

Observation

Family members and outside professionals are welcome to observe our program. To minimize program interruption, observation in the classroom must be scheduled one week in advance with a clinical representative. Siblings and other small children are not allowed in the classroom during these visits. The Center has a designated observation area that is always accessible to parents during center hours. Professionals and other care givers must schedule all observations one week in advance. Upon arrival to the Center, visitors must report to the office manager and sign-in on the visitors' log.

The Alpine Autism Center

OBSERVATION GUIDELINES

Please feel welcome in our learning center rooms. We are glad you have an interest in our program and hope you have an enjoyable and informative visit. As a courtesy to the children in our program, please observe the following guidelines during your time here.

1. Please sit in a place that you are comfortable yet allows for minimal distraction to the students. If a child approaches you, you may engage him minimally; taking the lead from the nearest teacher as to the level of your engagement. By interacting with a child you may unintentionally be diverting his attention from what he is doing. **Please do not engage a child unless he engages you first and the teacher who is working with the child indicates that it would be okay to respond.**

2. If you have any questions, please reserve them for the tour coordinator at the end of your observation. Please do not interrupt teachers with questions or comments as they work.

3. Please do not engage in conversation with other observers as it may distract the children who are busy learning in our program.

4. Please refrain from eating or drinking in front of the children.

5. *If* a child's treatment programs are available for you to read, please do not remove these programs from the room.

6. After you leave the observation, please respect the children's right to confidentiality and do not discuss the children or their treatment and/or progress with anyone outside The Alpine Autism Center.

7. Enjoy your visit and feel free to ask questions of the tour coordinator.

***I have read the above policies and agree to them. I understand that I am responsible for timely payment of all fees, and in the event of a third party payer, I am ultimately responsible for payment should the other party fail to do so.**

_____ _____

Parent/Guardian Signature Date

_____

Print Parent/Guardian Name

_____

Address

_____

City, State, Zip

_____

Day Phone

_____

Night Phone

_____

Email Address

Confidentiality Policy

It is the policy and practice of the Alpine Autism Center that all client information is held in strict confidence. It is also the policy that all employees, contractors, volunteers, parents, and agents sign this affidavit yearly as a reminder of our clients' right to confidentiality.

Breach of confidentiality is described as any indication of knowledge of any aspect of any client's treatment in all settings. Such indication might include the client's name or any identifying reference to the case except in situations as specifically defined by the Alpine Autism Center's Director. The client record is to be carefully safeguarded, as are billing records, correspondence, and reports generated.

If such breach of confidentiality occurs, inadvertently or purposefully, it will be regarded as willful misconduct and may result in disciplinary action which might include dismissal.

I have read this policy and understand and concur:

Signature

Please print name Date

CONSENT FOR TREATMENT

_____ (name of child), a minor, has a condition requiring evaluation and/or treatment. As a parent/guardian I apply for and consent to evaluation and treatment provided by the staff at Alpine Autism Center under the direct supervision of the Clinical Director.

Signed: _____ Date: _____

Relationship to patient: _____

CONSENT FOR ADMINISTRATION OF MEDICATION

I, parent/legal guardian of the above named child, authorize trained staff members of the Alpine Autism Center to monitor and administer medication(s) per my written directions. It is my responsibility to notify the staff, in writing, of any changes in medications, dosages, administration times, or procedures.

Medications:

_____
_____
_____
_____
_____

I parent/legal guardian of the above named child, authorize the staff of the Alpine Autism Center to act in my behalf in case of accident, injury or illness when immediate medical or surgical care is needed.

Medical Responsibility: I further agree to assume financial responsibility in the event of accident, injury or illness of my child while in the care of the Alpine Autism Center. If I cannot be reached, I hereby give permission to the above named individual to sign hospital operative permits for my child for such operations or dental procedures as are considered critically necessary by medical judgment, including administration of anesthesia.

_____ _____

Parent/Legal Guardian Date

_____

Printed Name

_____

Witness

MEDICAL EMERGENCY TREATMENT AND TRANSPORTATION RELEASE

The Alpine Autism Center has my permission to arrange for medical care and/or transport my child in case of an emergency. I hereby agree to indemnify and hold harmless The Alpine Autism Center and its agents, employees, or contractors, whether paid or volunteer, against any claims which may arise from any injury that occurs during transportation.

_____ _____

Parent or Guardian Printed Name Parent or Guardian's Signature

_____

Date

MEDIA RELEASE

_____I give permission for my child to be videotaped and/or photographed for educational or training purposes. Being able to videotape or photograph will allow us to analyze behaviors and teaching techniques and monitor progress as well as use them for training workshops we periodically perform for professionals.

_____I do not give permission for my child to be videotaped and/or photographed for educational or training purposes. Being able to videotape or photograph will allow us to analyze behaviors and teaching techniques and monitor progress as well as use them for training workshops we periodically perform for professionals.

On occasion, the Alpine Autism Center develops marketing material such as our website, brochures or class schedules. We are also on occasion featured on television, radio or other media at such times when they are covering a story on autism.

_____ I give permission for my child to be featured in television, radio or any other media. I understand that it is always the Alpine Autism Center intent to represent my child in a dignified and respectful manner. I would like to be contacted each time my child's image is going to be used.

_____ I do not give permission for my child to be featured in television, radio or any other media.

PERSONS TO RELEASE

I, _____, authorize the persons listed below to drop off or pick up my child, _____, from the Alpine Autism Center. I understand that only the persons listed below will be allowed to pick up my child.

Name	Driver's License #	Address	Phone Number

_____ _____

Parent Signature Date

CONSENT TO REQUEST/RELEASE INFORMATION

I hereby authorize the Alpine Autism Center to_____ obtain and/or _____ release any medical, psychological, school, or social records or information concerning the below-named individual. This information will be used for services I have requested.

Patient Name_____

_____

Date of Birth Social Security Number

Alpine Autism Center is authorized to exchange information with:

_____

Name Organization

_____

Name Organization

_____

Name Organization

AUTHORIZATION

I hereby certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has been taken to comply with it.

I understand that this consent will expire on _____

A copy of this authorization is to be considered as valid as the original.

I release the Alpine Autism Center from all liability pertaining to disclosure of information concerning the records of the above-named individual.

_____

Signature of individual served

_____

Parent/Legal guardian (Representative of individual)

_____

Date of signatures

Please send information to: Alpine Autism Center
7875 Deer Hill Grove
Colorado Springs, CO 80919
(719) 955-3767

E-MAIL CONSENT TO COMMUNICATE WITH HEALTH CARE PROVIDERS

Patient/Guardian name: _____Date:_____

I request to communicate with my health care provider (s) using electronic mail. I realize that the following risks and benefits apply.

RISKS:

The confidentiality of e-mail communication cannot be assured.

- E-mail communication may be viewed by third parties.
- E-mail is sent across an open computer network and is generally unencrypted. It is thus accessible to prying eyes similar to a postcard.
- E-mail sent using an employer's e-mail system could legally be read by the employer.
- The biggest threat to the confidentiality of e-mail is not hackers intercepting messages, but messages that are mis-addresses, mistakenly forwarded to others, or are read using shared e-mail accounts or on computer screens when one forgets to lop-off.

BENEFITS:

- Use of e-mail may eliminate "telephone tag" between patient and health care provider.
- Non-urgent messages and questions may be communicated with less interruption that by phone.
- E-mail allows a written record of communication which can be a useful reference.

GUIDELINES FOR E-MAIL COMMUNICATION:

Appropriate uses of e-mail for medical communication include:

- Address and telephone numbers of referring facilities;
- Test results with interpretation and recommendation;
- Medication instructions and refill information;
- Before-admission and after-discharge instructions;
- Patient education;
- Questions and answers about issues discussed during a previous visit;
- Questions and answers about new symptoms by an established patient;
- Verification of future appointment dates/times;
- Other messages of a similar nature to the topics above.

E-mail SHOULD NOT be used to communicate:

- Emergencies and other time-sensitive issues
- Requests for medical advice before the patient-physician relationship has been established'
- Sensitive information, defined as any information that the patient would not want anyone other than the health care provider to have.

Additional Recommendation:

- Put patient name in the subject line;
- Keep copies of e-mail you receive from your health care provider;

- Your health care provider will be saving and printing e-mail messages to be filed in your medical record. Your health care provider may share your messages with his/her office staff or consultants if necessary. This consent form applies to all health care providers who are providing care to you at this clinic. E-mail correspondence may be terminated by either the patient of health care provider at any time.

I, _____ (name of patient/guardian) understand the risks, benefits, and appropriate uses of e-mail communication with my health care providers. I recognize that the confidentiality of medical information discussed in e-mail communication can not be assured and I accept that risk. I understand that it is my responsibility to identify for my health care providers any medical information that I expressly do not want communicated via e-mail. I agree to follow the guidelines listed above. I agree to follow the guidelines listed above regarding the appropriate and inappropriate uses of e-mail communication with my health care providers.

I have reviewed the information above and wish to proceed.

_____
Patient/Guardian E-mail Address

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness' Signature Date

TV/ VIDEO PERMISSION

I, _____, am the custodial parent and/or legal guardian of _____.
I give my permission for this child to view television and videos shown at Alpine Autism Center.

Student Name: _____

Date of Birth: _____

Parent/Guardian Signature:_____

Parent/Guardian Name (please print): _____