Welcome, and thank you for choosing the Developmental Disability Agency at Children's Therapy Place. Our certified therapists are excited about the opportunity to serve you and your child. We provide Habilitative Intervention, Habilitative Support, Family Training, and Therapeutic Consultation, and Crisis Intervention depending on the age and individual needs of your child. We serve children and adolescents through age 17 struggling with a variety of behavioral and developmental difficulties.

The first step in the process is to fill out and return this intake packet and to meet with the Clinical Supervisor to ensure that staffing is chosen to best suit your family's needs. We pride ourselves in choosing a therapist for your family and child that will be a good fit and someone that you will feel 100% comfortable with. Please let us know at any point if you would prefer to work with someone else, as not all personalities fit together.

Please feel free to contact Brandon, Mitch, Kacey, Liz, or Rachelle if you would like to discuss your child's needs, have concerns, need information, or need further resources.

Thank You,

Kacey Mueller
Mitch Rice
Brandon Winebrenner
Liz Caroselli
Clinical Supervisors

Rachelle Williams
DDA Administrator

Emergency Contacts

Client Name: _____
Home Address: _____
Parent(s) Name(s): _____
Home Ph: _____Cell Ph: _____
Work Ph: _____Other: _____

Emergency Contact 1: _____Ph:_____
Emergency Contact 2: _____Ph:_____

In my absence, you have my permission to leave _____with the
(Client)
following people:

_____

_____

Client will not be left in the care of anyone not listed without written consent.

Emergency Procedure:

In the case of an emergency, or the inability to locate parents when dropping off client, staff will attempt to contact emergency contacts listed. If an appropriate person is unavailable, staff will contact supervisor. No client under the age of 18 will be left unattended without express written permission of parent or guardian.

Authorization to Transport

By signing this form, I authorize a Children's Therapy Place representative to transport my child in a company or personal vehicle, while providing therapy services.

Consent to Treat in a Medical Emergency

By signing this form, I consent for my child to be treated in a medical emergency at the nearest emergency room. If an emergency should occur, any and/or all contacts listed above will attempt to be contacted.

_____ _____
Client Signature Date

_____ _____
Legal Guardian/Representative Signature Date

_____ _____
Agency Representative Signature Date

Updated 4/26/2018

Children's Therapy Place Inc.
Client Medical/History Information

Child's Name:		DOB:	Diagnosis:
Address:		Medicaid #:	SSN:
Mother:	Home phone:	Cell:	Work phone:
Email:			
Father:	Home phone:	Cell:	Work phone:
Address/Email (if different from above):			
Siblings and/or others living in the home:			
School:	Grade:	Teacher/Case Manager:	
Physician:		Ph:	
Dr. Leavell or other psychologist/specialist(s):			
Immunizations current? Yes No *please bring a copy for our records*			
Speech, Occupational and/or Physical therapist(s):			
Service coordinator:	Agency:	Ph:	

Pregnancy/Birth:
Did mother visit the physician more than 5 times during pregnancy? Yes No
Did mother begin physician care after 28 weeks (7 months) of pregnancy? Yes No
Mother's age at time of birth: _____
Gestational age: _____ Child's birth weight: _____ Length: _____
Type of delivery: Vaginal Breech Cesarean Was labor induced? Yes No
Were instruments used? Yes No Did baby stay in NICU? Yes No
Hospital where baby was born: _____ or birth outside of hospital

Were any of the following conditions present at birth? (Circle)

Paralysis	Did not cry	HIV positive	Jaundice
Fractures	Cord around neck	Blue color	Birth defects
Needed oxygen	Breathing problems	Bruised head	Multiple births
Seizures	Low pulse rate	Unresponsive	

Other: _____

Please check any of the following conditions that existed during pregnancy and indicate which month the problem occurred:

Anemia _____
Elevated blood pressure _____
Toxemia _____
Heart problems _____
RH blood sensitization _____
Bleeding _____
Seizures _____
Medications _____
Drugs/alcohol _____
Pesticide exposure _____
X-ray exposure _____
Injury _____
Chronic kidney disease _____
Virus or serious illness _____
Problems with placenta _____
Diabetes _____
Problems with amniotic fluids _____
Smoking (# smoked per day) _____

Are any of the following conditions present in your child's immediate family?

Condition	Who	Comments
Autism		
ADD/ ADHD		
Learning disabilities		
Speech/language disorder		
Hearing impairments		
Vision impairments		
Mental retardation		
Birth defects		
Mental health issues		
Epilepsy (seizures)		
Cerebral palsy		
Abuse		
Alcoholism		
Chemical dependency		
Cancer		
Heart disease		
Diabetes		

Has the client or family participated in any of the following programs? (Circle)

Personal Care Services
Child protection
High risk infant care
High risk maternal care
Immunizations
Medicaid
Well Child Clinic
Head Start
Indian Health Services
EPSDT health check
Social security
Katie Beckett program
WIC Nutrition program
Food stamps
Financial assistance
Maternity clinic
Family planning clinic
Children's special health program

All children learn to do things at different times. Think back to when your child started doing these different things and indicate the age, or check the "not applicable" box if your child is not doing the activity.

Activity	Age	N/A	Activity	Age	N/A
Respond to loud sounds			Use 2-3 word sentences		
Grasp rattle			Recognize familiar pictures		
Lift head and chest while on tummy			Feed self with spoon		
Smile			Walk up steps alternating feet		
Reach for and pick up objects			Ride a tricycle		
Roll from stomach to back			Put on shoes		
Transfer objects from one hand to other			Use 3-5 word sentences		
Sit without support			Use the toilet		
Pull to standing position			Dress and undress with little help		
Crawl on hands and knees			Wash hands alone		
Drink from a cup			Give first and last names		
Wave bye-bye			Catch a large ball		
Feed self finger food			Bathe self		
Walk without help			Dress alone		
Use 8-10 words that are understood					

When did you first notice that your child had delays?

_____

Please list any hospitalizations or operations in your child's medical history and dates they occurred.

_____

_____

Please list any serious accidents or injuries and dates they occurred.

_____

_____

_____

_____

Does your child have frequent illnesses or infections? Describe:

_____

_____

_____

Does your child experience any of the following?

Vision problems: (squinting, crossed eyes, getting very close to TV, books, etc., rapid eye movements, wears glasses, other) _____

_____

_____

Hearing problems: (chronic ear infections, pain in ear, discharge from ear, tubes in ears, hearing aid, other) _____
_____
_____

Special medical needs/devices: (AFO's, back brace, wheel chair, other) _____
_____

Has your child ever had a convulsion or seizure? Yes No age: _____

Please list any medications your child is currently taking, dosages and reason for taking:
_____
_____
_____
_____

Last visit to the dentist: _____
Last visit to the physician: _____

Please list any allergies your child has (food/medication/etc): _____
_____

Are there any diet/food restrictions: _____

Approximately how many hours per night does your child sleep? _____

Does child take a nap? Yes No What time of day? _____ How long? _____

Does your child enjoy being hugged? Yes No Cuddled? Yes No

Have there been any legal/custody concerns involving your child? Yes No
Describe: _____

Does child worry a lot or seem to be afraid? Yes No
Describe: _____

Have there been any major changes in the child's life in the past year? Yes No
Describe: _____

What are your primary needs/concerns for your child at this time?
_____
_____
_____

What are your long term goals for your child?

_____
_____
_____
_____

What special interests or activities does your child have? What motivates them?

_____
_____
_____
_____

How many hours per week of therapy would you like your child to access during therapy?

_____

Which days of the week and hours of the day would you like therapy? (Please check days you are requesting and start and end times for each day)

- **Monday** _____
- **Tuesday** _____
- **Wednesday** _____
- **Thursday** _____
- **Friday** _____
- **Saturday** _____

Please list any other information that would help us provide the best possible services for your child.

_____
_____
_____
_____
_____
_____
_____

Thank you for taking the time to fill out this information!
When Completed Please Return This Form To:
6855 W Fairview Ave Ste 120, Boise ID 83704
(208) 323-8888 Fax (208) 323-8889

Medication List

Client Name:

Medication	**Comments**

*This form is updated on an annual basis or more often if needed

Updated 4/26/2018

Children's Therapy Place, Inc.
Participant's Rights

Children's Therapy Place, Inc, in accordance with IDAPA 16.03.21.905 (01-02) (7-1-11) and Idaho Code Section 66-412 and 66-413, ensure the following rights to each client receiving therapy service:

01. **Participants Rights Provided Under Idaho Code**, Section 66-412, provide the following rights for participants:

a. Humane care and treatment; (7-1-11)
b. Not to be put in isolation; (7-1-11)
c. Be free of mechanical restraints, unless necessary for the safety of that person or for the safety of others; (7-1-11)
d. Be free of mental and physical abuse; (7-1-11)
e. Voice grievances and recommend changes in policies or services being offered; (7-1-11)
f. Practice their own religion; (7-1-11)
g. Wear their own clothing and retain and use personal possessions; (7-1-11)
h. Be informed of his medical and habilitative condition, of services available at the agency, and the charges for the services; (7-1-11)
i. Reasonable access to all records concerning himself; (7-1-11)
j. Refuse services; and (7-1-11)
k. Exercise all civil rights, unless limited by prior court order. (7-1-11)

02. **Additional Participant Rights**. Children's Therapy Place also ensures the following rights for each participant:

a. Privacy and confidentiality; (7-1-11)
b. Receive courteous treatment; (7-1-11)
c. Receive a response from the agency to any request made within a reasonable time frame; (7-1-11)
d. Receive services that enhance the participant's social image and personal competencies and, whenever possible, promote inclusion in the community; (7-1-11)
e. Refuse to perform services for the agency. If the participant is hired to perform services for the agency the wage paid must be consistent with state and federal law; (7-1-11)
f. Review the results of the most recent survey conducted by the Department and the accompanying plan of correction; (7-1-11)
g. All other rights established by law; and (7-1-11)
h. Be protected from harm. (7-1-11)
i. Be free from coercion (7-5-17)

The purpose of this section is to inform you of rights as a participant receiving services from Children's Therapy Place, Inc.,

I. Right to Voluntary Services

If you are a legal adult (eighteen (18) years of age in Idaho), you have the right to request voluntary services. You have a right to:

- A personal, individualized assessment of your needs,
- An individualized service plan, which will be reviewed regularly, developed with your input, and implemented with your consent,

- Services beginning within a reasonable time and ending when they are no longer needed or effective,
- Another opinion regarding services provided, (However, seeing someone outside of this setting is done at your expense.)
- Referrals to other competent professionals and sources of help as indicated by your service plan.

II. Right to Refuse Services

You have a right to:

- refuse any form of service or treatment unless it has been ordered by the court or in an emergency situation when necessary to prevent harm to yourself and others, (If you must receive services not by your own choice, you have the right to a lawyer, a court hearing, and an appeal of the decision to a higher court. If you cannot afford a lawyer, the court will appoint one for you.)
- refuse service with your primary clinician and request another practitioner in this setting or a referral to another setting,
- be informed that without services, your situation may get worse,
- refuse to be filmed or audio-taped without your written permission,
- refuse to take part in research studies without your written permission.

III. Right to Confidentiality/Privacy

All information is confidential to protect you privacy. You have a right to:

- privacy and confidentiality,
- determine the amount of information to be released, whether to or from anyone outside this agency, by signing a permission form,
- sign a Release of Information form that is specific to each situation when information is to be released, (You will not be asked to sign a "blanket" permission for release of information.)
- determine the length of time that information may be released and cancel your permission at any time.

IV. Right to Information

You have a right to verbal and written information about:

- your rights, role, and responsibilities as a client in this agency,
- your primary clinician's rights, role, and responsibilities in this agency,
- what you can expect during your service process-appointments, costs, handling of emergencies, and other practices and procedures of this agency, as they affect you,
- any rights that are taken away and right to review of this action by requesting a Grievance Procedure,
- your primary clinician's credentials and professional code of ethics,
- means to contact your primary clinician in both emergency and non-emergency situations,
- the name of and means to contact your primary clinician's supervisor,
- procedures for reviewing your clinical records,
- reasonable access to all records concerning yourself.

Protection and Advocacy

People with various disabilities are entitled to protection and must have access to advocacy in securing the benefits, services, and rights to which they are entitled. A current and complete list of these advocacy and protection services which persons with disabilities may call upon, including telephone numbers and addresses is listed below.

The following are resources, which persons with developmental disabilities may call upon:

Advocacy:

Disabilities Rights Idaho
www.disabilitiesrightsidaho.org
info@disabilitiesrightsidaho
Toll Free: (866) 262-3462 or
(800) 632-5125
(208) 336-5353
4477 Emerald St,, Suite B100, Boise ID 83706

The Arc Inc.
www.thearcinc.org
(208) 343-5583
4402 Albion St, Boise ID 83705

National Alliance for the Mentally Ill (NAMI)
www.nami.org
800-950-NAMI (6264)

Legal Aid Services, Inc.
www.idaholegalaid.org
(208) 345-0106
1447 S. Tyrell Ln. Boise, ID 83706

Protection:

Idaho Parents Unlimited (IPUL)
www.ipulidaho.org
(208) 342-5884
4619 Emerald St., Boise ID 83706

Idaho Commission on Aging
www.idahoaging.com
(208) 334-3833
341 W. Washington 3rd Floor Boise, ID 83702

Area Agencies on Aging
(208) 908-4990
125 E 50th St, Garden City ID 83714

Child Protection Services
(855) 552- (KIDS) 5437
(208) 334- (KIDS) 5437
1720 Westgate Dr, Boise ID 83704

Boise Police- Special Victims Unit
www.boisepolice.org
(208) 577-6241

Women's and Children's Alliance
http://www.wcaboise.org/
(208) 343-3688
720 W. Washington St. Boise ID

Verification of Receipt of Participant's Rights Agreement
And
Protection and Advocacy Resources
(16.03.21.905)

By signing this form I verify that I have read, understood, received a verbal explanation, and received a copy of my Participant Rights and Protection and Advocacy contacts as a participant receiving services from Children's Therapy Place, Inc. My signature also confirms that I have had a chance to review and discuss each right listed with an employee of Children's Therapy Place. This was done pursuant to relevant language in IDAPA Code and the Medicaid Provider Agreement.

Participant Name (Print): _____

Participant/Guardian Signature: _____

Authorized Children's Therapy Place, Inc. Representative:

_____
Signature

_____
Date

Parent Handbook

Habilitative Support

Habilitative Intervention

At Children's Therapy Place we want to maximize the time your child spends during therapy and provide the highest quality services possible.

The following are guidelines to be aware of as you and your child navigate through the therapy process.

We look forward to a successful and collaborative therapy relationship!

Updated 4/26/18

Therapy Curriculum
Habilitative Support and Habilitative Intervention are play-based therapies. It should appear that your child is learning through play. Due to the nature of developmental disabilities it may take an extended amount of time for changes to occur. Repetition and consistency is ideal for skill acquisition. If you have concerns about your child's therapy please call the office to discuss ways learning can be improved for your child.

Therapy Schedule
Consistent therapy is important for best results. When developing your child's therapy schedule with your Clinical Supervisor, please make sure to discuss your child's other commitments and responsibilities, such as other therapy appointments, regularly scheduled doctor's appointments, etc. We appreciate the effort it takes to make sure your child is attending therapy consistently.

Just as we expect our employees to be on time for your therapy session, please make sure to have your child ready to participate in therapy as well when your therapist arrives.

Preparing for Therapy
Please feed your child a healthy meal prior to starting therapy. If this is not possible, talk to your therapist about including meal time in therapy.

If your child is not potty trained or is currently potty training, please remember to pack a bag of spare clothes, diapers, wipes, etc for your therapist if they leave the home.

Please be aware of the expected weather for the day. If it is supposed to be cold remember to send your child with a jacket! If it is supposed to be warm remember to send your child with sunscreen and a water bottle!

Children's Therapy Place trusts their employees and those individuals that we are sending to your home. But just as you would with any stranger coming into your home, please remember to put away your valuables and do not leave money lying around the home. Children's Therapy Place does complete a full criminal history background check as well as a comprehensive clean driving record verification prior to introducing any employee to a client.

Therapy Space
If your child participates in home-based therapy, please make sure that a clean quiet area is available. Please turn off the TV and minimize other distractions, such as family members and siblings coming and going. Siblings and other children must have other adult supervision during therapy.

Therapy Locations
Habilitative Support and Habilitative Intervention are home, community, and/or center based. The decision of where therapy should occur is based on your child's specific strengths and needs. Various locations are often utilized each week to expand the child's learning across several settings and to generalize skills.

Cancelling Therapy/ Illness
If therapy needs to be cancelled, please give your therapist at least 24 hours notice. If your child is sick please call the therapist or office to cancel therapy. If it is after business hours and you do not have your therapist's phone number please leave a message on the office voicemail. If your child is too sick to go to school then they are too sick to participate in therapy. A sick child cannot learn effectively and is unable to participate in therapy in a meaningful way. Keeping a sick child home prevents the spread of illness and allows the child an opportunity to rest and recover.
If your child is not feeling well and you are not sure whether or not to cancel therapy, below are some helpful guidelines to aid you in deciding. If your child is/has:

-Coughing
-Sneezing
-Throwing up
-Fever
-Runny nose with green or yellow discharge
-Undiagnosed skin rash
-Pink eye

Children may resume therapy once they have been fever-free (or symptom free) for 24 hours without the use of medicines.
*Please refer to our cancellation policy for further information.

Therapist's Paperwork
Your therapist has a time-sheet (called a "CSR") that will be completed daily. For Habilitative Support, the therapist should review their CSR with you at the end of therapy session to show you both their time and the progress your child made on their goals.

When changes in the therapy schedule occur please make sure there is a note of it on the therapist's time sheet. This can simply be written on the side that therapy was canceled due to illness of the child or a family vacation. Please initial these notes.

Policy Changes
Our policies will not change without written notice to all families and clients of Children's Therapy Place.

Supervisor Observations
At least once each month, your therapist's supervisor will come to your home or meet your child and the therapist out in the community to observe the therapy being provided. This is a Health and Welfare required practice.

Transportation & Therapy
If you allow, your child's therapist may transport your child during therapy. Your child must ride in the backseat of the therapist's car. If required by law for your child's height and weight, you must provide a car seat or booster seat for your child to use in the therapist's car.

Medications & Special Medical Needs
Employees of Children's Therapy Place are strictly forbidden from handling, transporting, dispensing, opening, discarding, distributing, etc your child's medications.

We rely on you to inform and train your child's therapist to the best of your abilities about any special medical needs your child may have. For your child's safety, tasks such as positioning, lifting, etc should be demonstrated and modeled by you for the therapist before the therapist is expected to perform the task.

Discipline
Our goal is for your child to respond to the therapist's instructions and participate fully in therapy. Having the expectation that your child will follow the therapist's instructions conveys to the child that they CAN do this. Please allow the therapist to direct the therapy and work with your child. Try not to give directions to your child or try to "help" the therapist. The therapist will ask for your help when they need it. If your child seeks you out during therapy, empower the therapist by having your child return to the therapy session immediately. This teaches your child that the therapist is in charge during the therapy session and they need to follow their directions.

If your child becomes resistant or upset during therapy, please allow the therapist to work through your child's behavior without interruptions so they can continue therapy. This helps your child learn coping skills and to express their emotions in a positive way. This also teaches them to trust the therapist. Resistance frequently escalates before it gets better.

It is important to take a look at what your child's behaviors are during therapy and how they are being reinforced. We need to follow through with every request asked of the child. If, for example, we ask a child to "Come here" and we don't follow through, we have taught two unfortunate lessons: the child doesn't have to listen to us and the child might not learn what "come here" means. Following through is of utmost importance.

Employees of Children's Therapy Place will not take any part in time out discipline methods. If you would like to utilize time out during therapy then the therapist will wait quietly until you have completed your time out process then resume therapy. All employees of Children's Therapy Place are mandatory reporters of abuse and neglect.

Tutoring & Academics
Habilitative Support and Habilitative Intervention focus specifically on teaching your child functional life skills and learning ways to become more independent. We are not permitted to perform tutoring type tasks or assist with academic skills. The state of Idaho believes that academic tasks and tutoring assistance is the responsibility of the school district.

Other Therapy Services
Children's Therapy Place offers not only Habilitative Support and Habilitative Intervention, but Occupational Therapy, Physical Therapy, and Speech/Language Therapy services as well! If you would like to find out more about these additional services please call the office.

By working together as a team, we can help your child make positive steps towards independence. We enjoy the partnership we have created with your child and your family and will make every effort to assist your child in meeting their maximum potential.

If you have any questions regarding your child's therapy services, please don't hesitate to contact the office.

Children's Therapy Place
6429 W Interchange Ln
Boise, ID 83709
Phone: (208) 323-8888
Fax: (208) 323-8889
www.childrenstherapyplace.com

Hours of Operation:
8:00am to 5:00pm Monday through Friday

Receipt of Parent Handbook

By signing below I acknowledge that I have read and understand the Parent Handbook and agree to comply with the contents therein. I understand that I should contact the Clinical Supervisor, and/or Administrator regarding any questions that I might have concerning this document.

Signature _____

Date _____

Updated 4/26/18

Liability Waiver
For Animal Interaction

Child: _____

Children's Therapy Place Inc. encourages the development of its clients as they participate in Developmental Therapy and/or Intensive Behavioral Intervention (IBI) sessions. Opportunities such as interactions with animals are occasionally arranged by the employees of Children's Therapy Place Inc. to provide opportunities for children with disabilities.

By signing below I acknowledge the risks involved regarding animals and allowing my child to interact directly and/or indirectly with animals. I understand and agree that Children's Therapy Place and its employees are in no way liable for any accident or injury that my child may sustain through their interaction with animals during Developmental Therapy and/or Intensive Behavioral Intervention (IBI). I understand that this waiver is revocable by me at any time when a verbal or written recommendation is made.

My child is *not* allowed to interact with the following animals:

- _____

- _____

- _____

I understand that I should contact the Developmental Specialist, IBI Program Manager, DDA Director, or Agency Administrator regarding any questions that I might have concerning this waiver.

_____ _____
Parent/ Legal Guardian Date

_____ _____
Agency Representative Signature Date

Updated 4/26/18

Children's Therapy Place Inc.

We want to take your picture! This form is optional. It is a request, not a requirement.

- CTP has the unique ability to scan your child's picture onto documents associated with his/her care. This makes your child a smiling face rather than a name or account number.
- Your picture may also be used to promote services through posters, flyers, brochures, etc. We feel the best way to do that is to present snapshots of real clients participating in the therapy process.

CONSENT TO PHOTOGRAPH/VIDEOTAPE

I, the parent/guardian of _____ hereby give Children's Therapy Place, Inc., its agents, and/or assignees permission to use the photographs, motion pictures or any reproductions of my child's physical likeness taken of him/her in any manner it deems proper. I further allow Children's Therapy Place, Inc. to use my child's first name in Facebook postings, blogs, etc. I relinquish all rights, title, and interest I may have in the finished pictures, negatives and copies. I waive the right of prior approval and hereby release Children's Therapy Place, Inc., its agents, and/or assignees from any and all claims from damages of any and all kinds based on use of said material. I am of legal age and freely sign this release, which I have read and understand.

_____

Signature Date

Confidentiality Waiver
For Social Gatherings

Children's Therapy Place Inc. encourages the social development of its clients as they participate in Habilitative Support/Habilitative Intervention sessions. Opportunities such as play dates, group outings, and gatherings are often arranged by the employees of Children's Therapy Place Inc. to provide opportunities for children both with and without disabilities to spend time together and learn from one another.

By signing below I acknowledge that I have read and understand my rights to confidentiality as a client of Children's Therapy Place Inc. and choose to waive those rights for the purpose of allowing my child the opportunity to participate in social functions with other children. I understand that this waiver is revocable by me at any time when a verbal or written recommendation is made.

I understand that I should contact the Clinical Supervisor or administrator regarding any questions that I might have concerning this waiver.

_____	_____
Client Signature	Date
_____	_____
Legal Guardian/Representative Signature	Date
_____	_____
Agency Representative Signature	Date

Updated 4/26/18

Confidentiality Acknowledgement

Medicaid/ Insurance Policy: I request that payment of authorized Medicaid/insurance benefits be made to Children's Therapy Place on my behalf.

Health Insurance Privacy Accountability Act (HIPAA): Children's Therapy Place clients acknowledge that by signing this document, Children's Therapy Place may use identifying information about clients for the purpose of treatment, payment, and operation. Clients have the right to review all privacy notices before signing, have the right to requests and restrictions on disclosure, and have the right to revoke consent. Further information regarding HIPAA can be located under The Code of Federal Regulations 45 CFR 164.50. IDAPA 16.05.01 provides detailed information regarding use and disclosure of confidential information.

Confidentiality Policy: Children's Therapy Place clients acknowledge that by signing this document, all client information written/verbal and client interactions will be confidential. Information will only be exchanged with other Children's Therapy Place employees or individuals with signed releases of information who are actively involved in treatment/services.

Exceptions to Confidentiality: There are exceptions to complete confidentiality with which Children's Therapy Place must comply. Some of these exceptions include child abuse, suicidal clients, Tarasoff 'duty to warn', joint custody decrees, Guardian Ad Litems, Crime Victim Compensation Program, and subpoenas. Children's Therapy Place is required to report to the appropriate authorities when any of these circumstances are disclosed or present themselves.

Appointment Policy: All scheduled appointments must be kept or cancelled 24 hours in advance. If there are 3 missed appointments (no call prior to the scheduled appointment or no show) during the course of service, a client's services will be subject to discontinuation. A 30-day notice of possible discontinuation will be sent.

Payment is expected at the time of service, when applicable.

By my signature below, I affirm that I have read or have had explained to me the 'Confidentiality Acknowledgement' of Children's Therapy Place. My signature also confirms that I have had a chance to review and discuss the 'Confidentiality Acknowledgement' with an employee of Children's Therapy Place and that I have received a copy of the 'Confidentiality Acknowledgement'.

_____ _____

Client Signature Date

_____ _____

Legal Guardian/Representative Signature Date

_____ _____

Agency Representative Signature Date

Grievance Acknowledgement

All Children's Therapy Place clients and/or their representative will have the right to file grievances in regard to services rendered, environmental amenities and personnel and peer issues. All Children's Therapy Place personnel will be advised that all grievances must follow the procedure as described. If a staff member of Children's Therapy Place refuses to assist a client they will be immediately terminated. Should a client or their representative choose to use this procedure, it will in no way adversely affect their care of treatment at Children's Therapy Place.

When a client or their representative files a grievance, they will be encouraged to involve a spokesman at all stages of the process. Steps for the process will be as follows:

1. The grievance will be reviewed directly with a Children's Therapy Place employee within 5 business days of the action being grieved.
2. The grievance will be reviewed and documented by the Children's Therapy Place and brought to the attention of the supervisor for resolution.
3. If the grievance cannot be settled the issue will be brought to the next higher level of supervision for resolution, and continue until it has reached the Owner/Administrator.
4. At each level of supervision a resolution should be reached or taken to the next level within 48 hours. The time frame for a resolution should not exceed 10 business days or it should reach the Owner/Administrator.
5. An impartial arbitrator will be called upon to resolve the grievance if a resolution is not met between the client and the Owner/Administrator. A meeting will be scheduled with the client and/or their representative, the Owner/Administrator, and the program director within 5 business days.

Once concluded, the grievance forms will be filed with the program director and in the administrative files.

By my signature below, I affirm that I have read or have had explained to me the 'Grievance Acknowledgement' of Children's Therapy Place. My signature also confirms that I have had a chance to review and discuss the 'Grievance Acknowledgement' with an employee of Children's Therapy Place and that I have received a copy of the 'Grievance Acknowledgement'.

_____ _____

Client Signature Date

_____ _____

Legal Guardian/Representative Signature Date

_____ _____

Agency Representative Signature Date

RELEASE OF LIABILITY FOR MINOR CHILD AND PARENTAL CONSENT AGREEMENT

This agreement waives important legal rights. Read it carefully before signing. Your signature indicates that you understand and agree to its terms.

Children's Therapy Place, Inc. ("CTP") provides a broad range of therapy services for children with special needs.

Two of the therapy services offered by CTP include Habilitative Intervention(HI) and Habilitative Support (HS). HI/HS may involve the therapist and the child traveling into the community to engage in various activities that will stimulate the child and assist the therapist in teaching the child new skills, ideas and approaches to problem solving. HI/HS Intervention allows for a therapist to transport the child in the therapist's vehicle to and from events and activities in the community.

CTP believes that HI/HS is an important aspect of the services it offers, but is also aware of the potential risks involved, including, but not limited to, injury to the child arising from a vehicle accident or from the activities that the therapist and child engage in while in the community.

CTP wishes to offer HI/HS services, but will do so only in exchange for an agreement by the child and his or her parents or legal guardian to waive and release CTP and its therapists from any claim for injury by the child arising from transporting or engaging in HI/HS activities with the child.

Waiver, Release, Hold Harmless and Indemnity Agreement

1. I, the parent or legal guardian of _____ ("minor child"), understand and acknowledge that there are certain risks of injury to my minor child associated with his or her participation in HI/HS. I understand and acknowledge that these risks of injury include, but are not limited to, injuries that may arise during the transportation of my minor child to and from activities in the community and my minor child's participation in activities in the community. Recognizing these risks, I voluntarily choose to allow my minor child to participate in HI/HS services provided by CTP.

2. In consideration for CTP allowing my minor child to participate in its HI/HS services, I, and my minor

Parent/Guardian Initials _____ _____

child, voluntarily agree to waive any and all claims against CTP for injury to my minor child that may arise as a result of my minor child participating in HI/HS. Neither I nor my minor child, nor any party acting on behalf of me or my minor child, will bring a lawsuit or otherwise assert any claim against CTP for any injury to my minor child arising from his or her participation in HI/HS, and forever release CTP from any and all such claims. I also voluntarily agree to hold CTP harmless and indemnify and defend CTP from any claim for injury that may arise from my minor child participating in HI/HS – in other words, I voluntarily agree to assume all of the costs, including attorney fees, necessary to defend CTP against any claim arising from my minor child's participation in HI/HS. This agreement to waive, release, hold harmless, defend and indemnify CTP includes any claims arising from the negligent acts or omissions of CTP, and all other claims, including, but not limited to, personal injury, wrongful death, property damage, products liability, breach of contract or breach of warranty, or otherwise.

3. I understand that HI/HS includes, but is not limited to, the transportation of the minor child by CTP or its therapists to and from activities in the community, and the minor child's participation in the activity.

4. I understand and acknowledge that the activities in the community that CTP therapists and my minor child may engage in are varied and may include physical activities and the risks associated with participating in physical activities.

5. I understand and acknowledge that my, and my minor child's, agreement to release and hold harmless, defend and indemnify CTP extends to, but is not limited to, CTP's therapists, employees, agents, representatives, shareholders, principals, directors, volunteers, owners, contractors and successors.

6. I understand and acknowledge that this Agreement shall be governed by Idaho law without. regard to any conflict of law principles. Any legal action involving this Agreement shall be brought in the Fourth District Court in and for Ada County, Idaho.

7. I understand and acknowledge that this is the entire agreement between me and my minor child and CTP. I understand and acknowledge that this Agreement cannot be amended or modified, either orally or by the actions or course of conduct of CTP, except in a subsequent written agreement signed by all parties.

8. By signing this Agreement, I represent that I have read this Agreement and that understand the terms, words and language used in this Agreement and that I and my minor child intend to be legally bound by this Agreement. By signing this Agreement, I acknowledge that I and my minor child have given up substantial legal rights, that I am aware of the legal consequences of signing this Agreement and I do so voluntarily and without any inducement,

Parent/Guardian Initials _____ _____

assurance or guarantee. By signing this Agreement, I represent that I am the legal parent or legal guardian of my minor child. I also acknowledge that I sign this Agreement on behalf of my minor child and that my minor child shall be bound by the terms of this Agreement.

I have had sufficient time to carefully read this Agreement. I understand the contents of this Agreement and voluntarily sign it with full knowledge of its legal significance. I am aware that I am waiving and releasing certain legal rights that I, or my minor child, may otherwise have.

_____
Printed name of Legal Parent/Guardian #1

_____ _____
Signature of Legal Parent/Guardian #1 Date

_____
Printed name of Legal Parent/Guardian #2

_____ _____
Signature of Legal Parent/Guardian #2 Date

_____
Printed name of Agency Representative

_____ _____
Signature of Agency Representative Date

Attendance Policy Contract

Dear Children's Therapy Place Families,

At Children's Therapy Place we aim to provide the most compassionate, comprehensive care for your children. We pride ourselves on the dynamic and integrative services offered at our 4 Treasure Valley locations.

We also value your commitment to your children's services both at home and in our clinics. Maintaining your child's attendance to therapy sessions is vital to their ability to achieve their goals and make progress. In consideration of this, please take a moment to review our attendance policy.

Attendance Policy

Children's Therapy Place would like every client to maintain 90% or better attendance to their scheduled therapy appointments. If you need to cancel or reschedule an appointment for your child, please observe our 24 hour cancellation policy and let your therapist know. For DDA services, Children's Therapy Place does have a "Substitution Policy". You may contact a Clinical Supervisor for questions regarding this policy.

The following procedures apply to missed appointments.

- A missed scheduled appointment will result in a phone call from your child's provider or CTP supervisor to reschedule the missed appointment.

- A second missed appointment without 24 hours prior notice will result in a phone call from a CTP supervisor to ensure your child's appointment time best accommodates your schedule.

- If there is a third missed appointment without 24 hour prior notice, your child will be discharged from regular services at Children's Therapy Place. A formal Discontinuation of Services Letter will be mailed to you to inform you that if you wish to re-establish services, your child will be placed on a waitlist pending your confirmation of a consistent schedule.

We understand that extenuating life and health circumstances can make meeting our attendance policy difficult, which is why communication with our staff is crucial. We will use discretion in determining both the nature and frequency of absences when enforcing our attendance policy.

Thank you for your cooperation.

Respectfully,

Children's Therapy Place

By signing below, I confirm that I have read and understand Children's Therapy Place attendance policy and agree to its terms.

Parent/Guardian Signature:_____ Date:_____