

Priority scheduling deadline **March 29, 2019**

For more information call (408) 244-2005 or email [pgarza@socialthinkingsc.com](mailto:pgarza@socialthinkingsc.com)

Required for **ALL CLIENTS**:

- Application Checklist (this page)
- Registration Form.
- Guardian Permissions Form.
- Clinic Policies.
- HIPPA Email Consent Form (if you would like to submit your application via email)
- Most recent** reports
  - Individualized Education Program (IEP)
  - Psycho-educational assessment
  - Neuropsychological evaluation
  - Speech and language assessment/report
  - Doctor's letter OR Report including medical diagnosis or letter from doctor (not required but helpful if seeking insurance reimbursement)
  - Other
  - None of the above (only check here if you do not have access to any reports)
- \$220 Deposit payable to Social Thinking Stevens Creek. Deposit applied to summer balance.

**In addition, \*NEW CLIENTS please include:**

*\*You are considered a NEW CLIENT if you have not attended sessions in the past 6 months*

- Client Information Form.
- A recent picture of your child.
- A brief letter from you describing your child. (See "Client Information" for letter guidelines, pg 5).
- Teacher Questionnaire(s) (please have as many educators complete this form as possible).

**Please mail completed applications to:**

**Social Thinking – Stevens Creek  
3550 Stevens Creek Blvd, Ste 200  
San Jose, CA 95117**

**If you prefer to submit your application via email, please send to:**

**[pgarza@socialthinkingsc.com](mailto:pgarza@socialthinkingsc.com)**

***Emailed applications without a signed HIPAA email consent form cannot be accepted***

**You will receive placement confirmation and payment requirements by April 29th**

**Payment is due on or before May 10, 2019**

**Notes about completing your application:**

- **Incomplete applications cannot be appropriately profiled and will be placed on hold. Applications on hold cannot be profiled and will not be considered for scheduling.**
- **We will not process the application without the \$220 deposit.**
- We accept Cash, Visa, Master Card or Check (please write the **client's name and date of birth** on the check).
- The following Registration Form must be filled out completely even if you have attended sessions at our clinic before.
- The more selections and time slots you make available for us to choose from, the more likely it will be that we are able to place your child in our clinic.
- It is important to be as precise but as flexible as possible. This part of scheduling is complicated and we rely on the information you provide us. We will make every attempt to meet your needs. If your schedule changes after we complete our scheduling, or if you have very limited availability, there is a good chance that we may not be able to accommodate you.
- Please be aware that submitting your application does *not* guarantee placement in a group nor should it be assumed that because you attended a previous session you will automatically be enrolled without an application. Group placement is primarily based on matching similar students for the best possible learning environment and group interactions. It will also depend on students' availability.
- Those who do not receive placement after the first round of scheduling will be placed on the waiting list & contacted when an opening occurs; we generally are able to place the majority of applicants if we receive their applications by the **deadline of March 29, 2019**.
- Applications received before the scheduling **deadline of March 29, 2019** receive priority scheduling and earliest notification possible.

For admin use only:



REGISTRATION FORM FOR AGES 8-18
SUMMER 2019

For admin use only:

Application Deadline for priority scheduling: March 29, 2019

Returning Client? YES NO

Please return this application with \$220.00 deposit (see Clinic Policies on p.8 re: Cancellation Fees). Deposit will be applied to total cost of your summer program. Make deposit check out to: Social Thinking Stevens Creek

Payment due in full on or before May 10, 2019

Child's Name: \_\_\_\_\_

Age Birth date Gender Grade (in Sept. 2019)

PRIMARY CONTACT

Guardian #1 Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Guardian #1 Email: \_\_\_\_\_

Guardian #1 Home Phone #: \_\_\_\_\_

Can we leave a voicemail? Yes No

Guardian #1 Cell #: \_\_\_\_\_

Can we leave a voicemail? Yes No

Guardian #1 Work #: \_\_\_\_\_

Can we leave a voicemail? Yes No

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

SECONDARY CONTACT

Guardian #2 Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Guardian #2 Email: \_\_\_\_\_

Guardian #2 Home Phone #: \_\_\_\_\_

Can we leave a voicemail? Yes No

Guardian #2 Cell #: \_\_\_\_\_

Can we leave a voicemail? Yes No

Guardian #2 work #: \_\_\_\_\_

Can we leave a voicemail? Yes No

- INSTRUCTIONS: 1. Check the box for any session(s) you would like your child to attend. 2. For best results, indicate all options during that time period that your child can be available.

Table with 3 columns: Session A (4 Week Session June 10- July 3), Session B (4 Week Sessions July 8-August 1), and Other requests/preferred group mates. Each session column contains checkboxes for Group and Individual sessions, meeting times, and availability grids for Early and Late periods.

\*\* If your group falls on Thursday during Session A you will only be charged for 3 sessions due to the 4th of July holiday: Groups: \$675, Individual: \$487.50, Early Learner: \$397.50

**APPLICATION FOR AGES 8-18  
SUMMER 2019**



Client Last Name, First Name  
**CLIENT INFORMATION**

**SIBLINGS:**

Name and Age \_\_\_\_\_ Name & Age \_\_\_\_\_

Name and Age \_\_\_\_\_ Name & Age \_\_\_\_\_

Does the applicant live with both parents in the same household?  YES  NO

If no, please elaborate: \_\_\_\_\_

School Name and Location: \_\_\_\_\_

Current Educational Setting: \_\_\_ Public School \_\_\_ Private School \_\_\_ Home Schooled \_\_\_ Combination

Current Services: \_\_\_ SDC \_\_\_ RSP \_\_\_ OT \_\_\_ Speech \_\_\_ ABA \_\_\_ 1:1 Aide Other: \_\_\_\_\_

When was your child's last IEP? \_\_\_\_\_ Triennial Testing? (every 3 years): \_\_\_\_\_

Who referred you to our clinic? \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Please list the classes, topics or interests your child enjoys at school and at home:

\_\_\_\_\_  
\_\_\_\_\_

Please list the classes, topics or activities your child struggles most with at school or at home:

\_\_\_\_\_  
\_\_\_\_\_

If you would like to have your child's diagnosis included on your billing statements for insurance reimbursement, please include a report or letter, from your diagnosing physician, indicating your child's medical diagnosis.

Diagnosis: \_\_\_\_\_ Diagnosing physician/clinician: \_\_\_\_\_

**I. Please rate your child on a 1-5 scale (5 = great performance)**

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

**II. Please check all characteristics that describe your child**

Unmotivated	Oppositional
Anxious	Physically aggressive
Externally distracted	Verbally aggressive to peers or adults (describe)
Impulsive	Physically aggressive when upset towards adults
Rigid (my way or the highway attitude)	Verbally aggressive towards adults
Aloof/internally distracted	Withdrawn (may hide or emotionally shut down when upset)
Other (please describe):	

**III. Please write a letter describing your child.**

Including information about the following areas helps us obtain a clear picture of your child, which will increase our ability to find an appropriate placement. If you are a returning client, only include a letter if there are changes you would like us to keep in mind.

Please include the following areas in your letter:

- a. Your child's strengths and challenges related to functioning in the social world
- b. Describe their interactions with peers
- c. Describe their awareness of their challenges (e.g., Are they aware of how others perceive them, do they think that they are perceived as "different" from their peers?)
- d. How well do they understand that their actions and words affect others?
- e. How do they respond to every day problems, such as changes in the schedule, peer conflicts etc? What calms them down? What makes them more upset?
- f. What does your child do with unstructured time?



I give permission for my child to participate in community outings as needed during therapy sessions with a therapist employed by Social Thinking Stevens Creek.

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Contact telephone number

\_\_\_\_\_  
Date (Permission for 1 year from above)

Please list any food allergies or diet restrictions for your child: Needs Epi-Pen?  YES  NO

\_\_\_\_\_  
Please list any medications your child is prescribed:

Other adults permitted to pick up your child:

1. \_\_\_\_\_  
Print Name Clearly Phone

2. \_\_\_\_\_  
Print Name Clearly Phone

**Release of Videos and Images**

During sessions, we may cover a particular concept or strategy of the Social Thinking philosophy that illustrates a therapeutic technique or approach particularly well. In this instance we would like the opportunity to use this video in a training/ conference setting. The video will be used to educate parents and professionals about how to employ therapy techniques that are being discussed.

**I give permission for video or pictures of me/my child to be used in conference settings.**

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Print parent/guardian name

**Shared Guardianship**

It is the responsibility of the guardian(s) to alert STSC about special accommodations needed for parents who are divorced, separated, etc. For example, if both parents require a copy of any reports, if both parents need to give permission to move forward with a group, or if parents prefer not to attend meetings together.

Guardian initial



Please READ, INITIAL, and RETURN with the application packet.

I agree to follow the fee schedule and policies as noted (Please initial each section):

**Payment Policy**

*Payment for the summer session is due in full on or before MAY 10, 2019. Payment in full is the responsibility of the client, whether or not you are waiting for insurance reimbursement.* There is a \$25.00 charge for returned checks. If you have any questions or need to arrange a payment plan, please contact Mimi Pauline at (408) 244-2005 ext. 301 or by email mpauline@socialthinkingsc.com.

**Deposits:**

A great deal of time and effort is invested in processing applications and considering each child's placement. For this reason we ask families to submit a \$220 deposit when submitting an application. This deposit will be applied towards the student's balance for the summer session(s). If our clinic is not able to place your child in a summer session the full deposit will be refunded.

**Cancellation fees:**

We understand that unforeseen circumstances occur and occasionally cancelling your enrollment cannot be helped. We hope that families will make every effort to prioritize their child's program. However, due to the complexities of scheduling appropriate groups, cancellation fees will be charged as follows:

- Cancellations on or before April 10, 2019: No fee
- Cancellations between April 11 - May 10, 2019: Forfeit \$220 deposit
- Cancellations after May 11, 2019: Entire session fee is non-refundable

**Grouping Policy**

We strive to place all of our applicants in well matched groups. However, on occasion, when a group meets for the first time, the therapist may decide that the grouping is not appropriate. In these cases, every effort will be made to find an appropriate group for your child. If another group is not available or if you are not able to join the group for scheduling reasons, you will receive a refund. A full refund (minus the administrative fee) will be issued if your child does not attend the full group. A partial refund (less the administrative fee and fee for 1 session) will be issued if your child attends the entire group. Should you have concerns about your child's group, please contact the therapist as they will make the final decision as to whether a group is a good fit. We are unable to guarantee your child a group under any circumstances.

**Absences and missed sessions:**

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

**Sick Child Policy:**

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

**Client/Sibling Waiting Room Policy:**

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

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



**Policy for late child pickup:**

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

**Recordings for therapeutic purposes:**

The use of video, picture image and audio recordings are an essential component to Social Thinking therapy. We must be allowed to use these types of recordings in order for your child to participate in our program. Recordings will only be used within the group or individual session, not to be viewed by the public.

**Use of email to communicate Protected Health Information**

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

**Policy for processing insurance claims or other administrative tasks:**

We are a "private pay" clinic, meaning that all of our services must be paid for by the guardians of the client, or the adult client themselves. We do not accept 3<sup>rd</sup> party reimbursements. We recognize that obtaining insurance coverage may be a difficult process and we wish to do what we can to make this difficult process easier. We strongly encourage families to keep their own copies of their invoices and any reports or written updates we send to them each month.

- 1) We do NOT process insurance claims on behalf of a client or family. Our role is to provide records when and if they are requested by a family in order for the client/parent to submit such claims to their respective insurance company.
- 2) Some insurance companies will only reimburse for specific ICD-10 Diagnostic Codes. On your summer billing statement, we include the diagnostic code from medical reports provided by the client. We cannot enter a medical diagnostic code based on an educational classification alone. For any client that does not have a medical diagnosis on file we will use the default code, ICD-10: R69 Unspecified diagnosis (a non medical insurance code). Our statements also include a procedure code to reflect the service provided (group speech therapy or individual speech therapy).
- 3) Due to the intensive time and cost related to gathering information for an insurance claim, we will charge an administrative fee based on \$40.00 per hour for any administrative requests which include copies of previous invoices, reports, therapy notes, or calls to insurance companies.
- 4) We will not sign any contract offered to us by an insurance company that states that we agree to be paid a lesser fee than what we have established as our fee for service, even if the parent has paid our insurance administrative fee.

**Privacy Policy**

I have read/received a copy of the Social Thinking Privacy Policy (see attached). Please retain a copy of our Privacy Policy for your file.

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print guardian name





HIPAA EMAIL CONSENT

Important Information.

- HIPAA stands for the Health Insurance Portability and Accountability Act.
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.
- Information stored on our computers is protected.
- Most popular email services (Ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email.
- When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA.
- The guidelines state that if a client has been made aware of the risks of an encrypted email, and if that same client provides consent to receive health information via email, then a health entity may send that client personal medical information via unencrypted email.

By consenting to the use of email with Social Thinking® Stevens Creek, you agree that:

- Social Thinking® Stevens Creek may forward/receive emails as appropriate for placement, diagnosis, treatment, reimbursement, and other related reasons. As such, Social Thinking® Stevens Creek’s staff may have access to emails you send. Social Thinking® Stevens Creek will not forward emails to independent third parties without your prior written consent, unless as authorized by client or required by law.

**By signing this form, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of email between Social Thinking® Stevens Creek and me, and consent to the conditions outlined herein, as well as any other instructions that Social Thinking® Steven’s Creek may impose to communicate with me by email. Any questions I may have had were answered. I understand that this consent is valid until one year after the date below.**

I agree to ALLOW unencrypted email.

I understand the risks of unencrypted email and do hereby give permission to Social Thinking® Stevens Creek to send me personal health information via unencrypted email regarding \_\_\_\_\_.  
(Client name)

Guardian 1: \_\_\_\_\_  
Print Name Signature Date

Please clearly print ONE email address: \_\_\_\_\_

Guardian 2: \_\_\_\_\_  
Print Name Signature Date

Please clearly print ONE email address: \_\_\_\_\_

**\*We will only send/receive Personal Health Information from the email addresses written on this form.**

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It is important that you review this information, initial the box on the policies signature page and keep this for your records. This notice describes how information about our patients/clients may be used and disclosed and how they can obtain access to this information.

**Terms:**

Any medical information, which could in any way identify an individual client, is considered **Protected Health Information (PHI)**. PHI will be used and disclosed only as needed for Social Thinking (ST) to perform **\*Treatment, Acquire Payment and Health Care Operations (TPO)**. Any other disclosure will require the written authorization of the client. In general, use or disclosure of PHI for purposes other than treatment, or a disclosure requested by the client, is limited to the **Minimum Necessary** to accomplish the intended purpose. (*\*TREATMENT: ST PHILOSOPHY INCLUDES A TEN MINUTE "GROUP" PARENT MEETING AS A PART OF EACH GROUP SESSION TO DISCUSS WHAT HAPPENED DURING THE SESSION. DURING THIS TIME IT IS UNDERSTOOD THAT THE THERAPIST WILL SPEAK OPENLY TO ALL THE PARENTS ABOUT ALL THE STUDENTS IN THE GROUP WITH REGARD TO THEIR PARTICIPATION AND THINGS THEY NEED TO WORK ON AT HOME. THE THERAPIST WILL MAKE EVERY ATTEMPT TO HAVE THESE DISCUSSIONS IN A PRIVATE SETTING.*)

**Access:**

The following people will have access to PHI:

- ☞ The client when 18 years old or older.
- ☞ Parents or legal guardians of a minor.
- ☞ Parents of an adult client with written permission of client.
- ☞ Any person to whom the adult client has authorized, in writing, the release of PHI.
- ☞ ST staff and contractors who are involved in providing care or administrative assistance.
- ☞ The client's health insurance company, for payment purposes.
- ☞ Public Health Services and regulatory officials, when required by law.
- ☞ An appropriate authority when a determination is made that the client may pose physical threat to themselves or others.
- ☞ Courts, when the request is accompanied by a duly executed subpoena.

**Minimum Necessary:**

Requests for disclosure of PHI for all purposes will be reviewed by the ST Privacy Contact to assure that they meet the minimum necessary requirement.

**Patient/Client Rights:**

- ☞ Parent/Guardian of clients or adult clients have a right to see and obtain a copy of their PHI.
- ☞ Clients have a right to request limitations to the routine use of PHI for TPO.
- ☞ Clients have a right to request changes in their PHI.
- ☞ Clients have the right to see a list of all people to whom PHI has been disclosed. In order to meet this requirement, the Therapist must keep a disclosure log. The log must record all disclosures, both written and verbal.

**Security:**

Privacy measures are designed to protect the confidentiality of all PHI:

- ☞ All staff will receive instruction about and be familiar with the ST Privacy Policy.
- ☞ All staff will exert due diligence to avoid being overheard when discussing PHI.
- ☞ All records will be maintained in a secure environment.

**Information with regard to grievances:**

Clients who have complaints or concerns with regard to therapeutic management, please first contact your child's personal therapist to discuss your concern. If you feel that she has not been able to adequately address your needs, then please contact the Director. For all other questions, concerns or complaints please address them to the ST Office Manager. If the office manager cannot handle them directly, she will bring them to the attention of the relevant employee at ST. If you still feel that your complaint has not been resolved to your satisfaction, you can address complaints to the Secretary of the United States Department of Health and Human Services. Social Thinking will not retaliate against any individual for filing a complaint.

**Administration:**

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

**Additional Resources on Health Information Privacy**

Health Privacy Project  
Georgetown University  
[www.healthprivacy.org](http://www.healthprivacy.org)

Office for Civil Rights  
U.S. Department of Health & Human Services  
[www.hhs.gov/ocr/hipaa/](http://www.hhs.gov/ocr/hipaa/)

Please initial the box at the end of the ST Therapy Policies & Procedures contract indicating you have read and understood these privacy policies.

**This page intentionally left blank.**

**APPLICATION FOR AGES 8-18**  
**SUMMER 2019**

Dear Professional,



Client Last Name, First Name \_\_\_\_\_

**TEACHER QUESTIONNAIRE**

Date \_\_\_\_\_

*This student is either being considered for placement in a group or seeking an evaluation at our clinic. Please complete the information below regarding this student based on your experience.*

*Please return this form to the person who gave it to you or mail it to our office at the address below.*

Please complete by: \_\_\_\_\_

Grade of student: \_\_\_\_\_

Professional's name: \_\_\_\_\_

Relationship to the student: \_\_\_\_\_

*Please rate this student in the following areas:*

SKILL	COMMENTS	Above grade level	At grade level	Below grade level	Not observed
Math					
Reading decoding					
Reading comprehension					
Written expression					
Participating as part of a large group during class discussion					
Participating as part of a small work group in class					
Making and keeping friends during free time					
Ability to ask for help in class					
Organizational skills while in class					
Organizational skills from home to school and back					
Does this student stand out as unique in their interpersonal skills, either in class or out of class?	Yes or No, if Yes, please explain				
Do you anticipate that this student will encounter more challenges in future school years?	Yes or No, if Yes, please explain				
How would this student's peers describe them?					

**Further comments** (continue on back if necessary):