The Carrie Brazer Center for Autism
www.cbc4autism.org

2020-21 REGISTRATION PACKET* *Required Fields*

Child's Name * _____
Last Name First Name MI

Address* _____
Street City, State Zip Code

Child lives with ❑ Both Parents ❑ Mother ❑ Father ❑ Guardian, please add information below, if applicable

	Mother*	Father*	Guardian/Other (state relationship)
Last Name First Name Middle Initial			
Mailing Address* (if different from child)			
Home Phone*			
Work Phone*			
Cell Phone*			
Email*			

INFORMATION ABOUT CHILD:

Date of Birth* _____ Age _____ Gender* ❑ male ❑ female

Race* ❑ American Indian/Alaskan ❑ Asian ❑ Black/African American
❑ Pacific Islander ❑ White ❑ Other, please specify _____

Ethnicity* ❑ Hispanic ❑ Haitian ❑ Other, please specify _____

Country of Origin (Optional) _____

Is child Proficient in English* ❑ Yes ❑ No

Additional/Other language(s) spoken in the home:* ❑ Spanish ❑ Haitian-Creole ❑ Other _____ ❑ None

Child's Social Security Number* last 4 digits _____ ❑ No SSN ❑ Prefer not to give SSN

MDCPS ID Number* _____ ❑ No MDCPS ID ❑ Prefer not to give MDCPS ID

Current School* _____ Current Grade* _____

Does child have a documented disability?* ❑ No ❑ Yes *If Yes, do you have (check all that apply)*

❑ an Individualized Family Service Plan (IFSP; if under 3 yrs) ❑ an Individualized Education Plan (IEP) from the school system

❑ a Section 504 Plan ❑ a medical diagnosis from a doctor ❑ a diagnosis by a state certified/licensed professional (ex. psychologist)

❑ Disclosure by the parent or guardian describing the child's specific condition and/or need for accommodations

If yes, how would you best classify the type(s)? (Check all that apply):

❑ Autism Spectrum Disorders ❑ Intellectual Disability (or mental retardation) ❑ Visual Impairment (or blind)

❑ Chronic Medical Condition ❑ Learning Disability ❑ Other Disabilities, please specify

❑ Developmental Delay (under 5 only) ❑ Physical Disability _____

❑ Emotional and/or Behavioral Disorder ❑ Speech/ Language Impairment _____

❑ Hearing Impairment (or deaf) ❑ right ear ❑ left ear

Does the child have health insurance (ex. Private insurance, KidCare, Medicaid)?* ❑ Yes ❑ No

HEALTH CARE CONTACTS (*All fields required)

	Name*	Phone Number*	Address*	Email*
Physician				
Dentist				
Hospital of Choice* (EMT or Paramedic may override choice)				

ALLERGY INFORMATION

Allergies (food, insects medication, environment, please specify below) Does your child have an EpiPen ❑ Yes ❑ No

DIET INFORMATION

(Mark (X) for the foods & drink NOT permitted/allergic/does not like:

DRINKS				
❑ Coke	❑ Diet Coke	❑ Sprite	❑ Apple Juice	❑ Fruit Juice
❑ Soy Milk	❑ Rice Milk	❑ Dairy Milk	Prefers	Misc
LUNCH				
❑ Bread/Crackers	❑ Cheese	❑ Turkey	❑ Roast Beef	❑ Chicken
❑ Bologna	❑ Peanut Butter	❑ Jelly	❑ Rice Crackers	❑ Rice Cakes
Prefers		Misc		
FAST FOOD				
❑ Chicken Nuggets	❑ Hamburger	❑ Cheeseburger	❑ French Fries	❑ Ketchup
❑ Mustard	❑ Mayonnaise	❑ Onions ❑ Pickles	Prefers	Misc
SNACKS				
❑ Popcorn	❑ Lays Potato Chips	❑ Plantain Chips	❑ Raisins	❑ Watermelon
❑ Apples	❑ Strawberries	❑ Grapes	Prefers	Misc

Please include your child's psychological reports and most recent IEP with registration.

VOLUNTARY CONSENT FOR PHOTOGRAPHY AND COMMUNICATION

We ask your permission to make photos and/or videos during program activities and communicate with you about services you received.

Program participation will NOT be affected or denied if you choose not to consent.

Consent for Photography: I consent the staff of the Carrie Brazer Center for Autism, Inc. ("The Center") to take/ use still photographs, digital photographs, motion pictures, television transmission, and/or videotaped recordings hereinafter ("Recordings") of me, my children, or my wards for educational, research documentary, and public relations purposes. Any photos/videos may reveal your identity through the image itself without any compensation to you, your children or wards. Any and all Recordings taken of you, your children or wards shall be the sole property of the Center. With regards to the use of any Recordings taken of you, your children or wards, you hereby waive any and all present and future claims you may have against The Center, their staff, service providers, employees, agents, affiliates and Board members.

❑ Yes, I consent and authorize ❑ No, I do not consent and authorize

Photo Release: I irrevocably give The Center, it's subsidiaries, assigns and licensees the absolute right and permission to copyright, use, publish, alter and distribute any photographs, videos, films and/or web site posted via the internet in which my child may be included, taken at The Center, or while on field trips or in conjunction with the publicity, promotion or advertising for such attraction. I understand that these photographs, videos, film footage or web site postings may be used for publicity, advertising, art or promotion or for any lawful purpose whatsoever, without restriction.

❑ Yes, I consent ❑ No, I do not consent

Consent for Communication: I consent to allow The Center or others acting for The Center to contact me about services received.

❑ Yes, I consent ❑ No, I do not consent

Consent to be placed on mailing list: I want to receive information about The Center, child and youth issues, parenting information, and other topics.

❑ Yes, I consent ❑ No, I do not consent

RELEASE AND WAIVER

Personal identifying information of a child, or a child's parent or guardian, that is in the possession of The Carrie Brazer Center for Autism, Inc. is private information and cannot be given to anyone by The Carrie Brazer Center for Autism, Inc. without consent or permission**. I have the right to have The Carrie Brazer Center for Autism, Inc. keep my name and address from being given to anyone.**

By voluntarily signing below I waive my right for The Carrie Brazer Center for Autism, Inc. to keep my name and address private and I give my consent and permission for The Carrie Brazer Center for Autism, Inc. to release **ONLY** my name, address, phone and email address to children's interest groups

By voluntarily signing below, I release and discharge The Carrie Brazer Center for Autism, Inc. and its agents, employees, and servants from any and all claims, demands, rights, damages, costs whatsoever, in any way growing out of the release of my name, address, phone and email address to children's interest groups as described in the paragraph above.

I have read the above and I agree to allow The Carrie Brazer Center for Autism, Inc. to release ONLY my name, address, phone and email address to children's interest groups.

Signature Parent/Guardian _____ Print Name _____ Date _____

CHILD CARE AUTHORIZATION
Please fill out all sections.
Mark N/A if no information is available or information does not apply to child.

I/We, the undersigned Parent(s)/Guardian, _____ of _____,
(Print Parent's Name) (Print Child's Name)

Hereby grant Carrie Brazer and the staff at the Carrie Brazer Center for Autism, Inc., ("the Center") the authority to take temporary care of the following child: A

This grant of temporary authority shall begin on Aug 1, 2019 and remain in effect until August 31, 2020.
The above named caretaker(s) shall have the power to:

- Seek appropriate medical treatment or medical procedures in an emergency situation.
- Give the proper dosage of medicine on the allotted time while at the Center.
- Apply Safe Physical Management Techniques as described by Miami Dade County Public Schools, if needed.
- Sign release forms for sports.
- Sign release forms for field trips.
- Transport my child in privately owned vehicles of the Center and the staff of the Center.
- Authorize participation in Swimming and horseback riding
- Grant guardianship for all of the above purposes and all the associated activities, field trips, and swimming events that may pertain thereto without limitation.

Please note that the above names child has specific medical condition or allergies to either common allergens or medication, described as:

_____

_____

Does your child take medication? ❑ No ❑ Yes If so, which are the scheduled times and dosage? _____

_____

IN CASE OF EMERGENCY AND NEITHER PARENT CAN BE REACHED, PLEASE LIST NAME AND PHONE NUMBER OF RELATIVES OR FRIENDS WE MAY CONTACT. (minimum of 2 contacts)†

Name Relationship

Home Phone Work Phone Cell Phone

Name Relationship

Home Phone Work Phone Cell Phone

Name Relationship

Home Phone Work Phone Cell Phone

PERMISSION TO TRANSPORT MY CHILD TO & FROM THE CARRIE BRAZER CENTER FOR THE SCHOOL YEAR 2020-21†

Name	Relationship	Phone #1	Phone #2

NAMES OF THOSE WHO DO NOT HAVE PERMISSION TO TRANSPORT MY CHILD†:

Name	Relationship	Phone #1	Phone #2

Comments: _____

† *If extra names are necessary, please add on a separate sheet of paper.*

Initial Parent/Guardian _____

FAMILY MEDICAL HISTORY

Please check all that apply to your child :

❑ Heart Condition ❑ Diabetes ❑ Asthma ❑ Seizure Disorder ❑ ADD/ADHD ❑ Migraines ❑ Depression

Other (specify) _____

Names and ages of all siblings _____

Please list all family members, including the natural mother and father, grandparents, aunts, uncles, first cousins, brothers and sisters who have any chronic or serious illnesses. In addition, if there is any known inherited conditions that have occurred in any family member, however related, please list. Please include conditions such as high blood pressure, heart disease, kidney disease, allergies, asthma, skin diseases, seizures, birth defects, cancer, tuberculosis (TB), disorders of nutrition, and yeast related illnesses. *If extra names are necessary, please add on a separate sheet of paper.*

Relation to Student	Condition or Disease	Current Age	Age Condition Began

PRENATAL AND BIRTH CONDITIONS

Is the student adopted? ❑ No ❑ Yes, If Yes, please fill out any information you know within this section.

How many weeks was the birth mother pregnant? _____

What type of delivery did the birth mother have? (e.g. vaginal, caesarean, vacuum, etc.) _____

If other than a vaginal delivery, please state the reason. _____

Please list any anesthesia or pain medicines the birth mother used during labor or delivery: _____

Were any medicines used to bring on (induce) or strengthen the birth mother's contractions? ❑No ❑ Yes

Was the birth mother given any antibiotics during labor, delivery, or after delivery in the hospital? ❑No ❑ Yes Details if applicable:

_____

Place of birth _____ Length of time in hospital _____(days) ❑ not applicable

Measurements at birth: weight _____ Length_____

During the first week of life, did the baby have any illnesses or problems, have any tests or take any medication? ❑No ❑ Yes If so, please describe:

_____

Did the birth mother have any medical illnesses or treatments during pregnancy? (e.g. colds or viruses, diabetes, vaginal infections, hospitalization, IV treatments, Tylenol, antibiotics, cold medicine, antacids, alcohol, tobacco, "street" drugs, sonograms, amniocentesis, etc.) ❑No ❑ Yes If yes, please write what happened and when during the pregnancy. _____

_____

Has the birth mother ever during her life had any infections in the vagina such as bacterial or yeast (Candida)? If so, please describe:_____

_____

Did the birth mother take vitamins or other supplements during the pregnancy? ❑No ❑ Yes. Please list:

_____

DIETARY HISTORY

How long did the student breast feed? _____ Months, _____Years

During the period he/she was breastfeeding, did his/her mother experience any symptoms to her breast such as burning, itching or pain of the breast issue, sore nipples more than seven days after birth, plugged ducts or mastitis (breast infection): ❑Yes ❑ No If so, please describe:

_____

What formulas did he/she take and at what age? _____

When did he/she first begin to take solid foods? _____ Months.

Is he/she currently taking vitamins? ❑No ❑ Yes. If so what type? _____

Is he/she taking any other nutritional supplements? ❑No ❑ Yes. If so, what are they? _____

Please describe his/her current diet. (e.g. what are the favorite foods? Does he/she crave any foods? What is the pattern of meals, etc.)

_____

Does he/she have any symptoms from eating any particular foods? (i.e. food sensitivities?) _____

How often does he/she have a bowel movement? _____

Initial Parent/Guardian _____

INSURANCE INFORMATION

Primary Insurance _____

Name of Insured & relation to patient _____

Group Name & Number _____ Insured's ID Number _____

I hereby instruct my insurance company to make payment directly to The Carrie Brazer Center for Autism, Inc. ("The Center") at their current address for medical expense benefits otherwise payable to me under my current insurance policy, as payment towards the total charges for the services rendered by The Center. This is a direct assignment of my rights and benefits under this policy. This payment shall not exceed my indebtedness to the above mentioned center. This is a direct assignment of the rights and benefits under this policy. I also agree to promptly pay any balance of said professional service over and above this insurance payment and any amount, which my insurance policy renders as my responsibility. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any pertinent medical information to any insurance company once The Center has received payment for the same.

I understand and agree that regardless of the insurance status, I am ultimately responsible for the balance of my account. This includes any medical services rendered through The Center, including but not limited to, all insurance deductibles, co-payments, co-percentages and charges not covered by my insurance (if applicable). Arbitrary determinations made by insurance companies, such as "usual and customary fees" do not apply to this unless The Center is correct to the best of my knowledge. If I (or my spouse) change insurance coverage and do not notify The Center in a timely fashion, I agree to be responsible for the complete payment of any services rendered under their supervision.

INSURANCE ASSIGNMENT OF BENEFITS

I hereby acknowledge that The Center files insurance claims as courtesy on my behalf. I understand that I am ultimately responsible for any unpaid insurance claims submitted by The Center. I request that payment of insurance benefits due to me in my pending claim for speech, occupational or physical therapy services be made directly to The Carrie Brazer Center for Autism, Inc. I authorize The Center to release to my insurance company any information needed to determine these benefits or the benefits payable for related services. I agree that I will be personally responsible for the portion of my bill not covered by my insurance.

I agree that if it is necessary for The Center to use a collection agency and/or attorney to collect its bill for any services rendered at The Center, I will also be responsible for all their fees and costs incurred in the collection of my bill. I will be responsible for any other costs involved in the collection of my bill including court costs and attorney fees. I will be responsible for a late charge of 1.5% monthly on any unpaid portion of my bill beginning 30 days after the date of service.

Signature of Policy Holder _____ Date _____

Relation to patient: ❑ Parent ❑ Guardian

POLICIES & PROCEDURES FOR ENROLLMENT SCHOOL YEAR 2020-21

- I understand that I must abide by and follow the below set of guidelines to enroll my child in school for the 2020-21 school year or to register for any other program the center offers.
- I understand that there will be no parking spaces for the new school year. There will be a circular procedure to the arrival and dismissal. A staff, teacher, or office manager will be conducting drop off and pick up. Parents will drop off students to the staff, teacher, or office manager and will continue the proper circular procedure. Parents will not be allowed to walk their students to their classrooms.
- I understand that if I want to want to speak to a teacher, I must make an appointment. Appointments will be available on Wednesdays between 2:15pm-3:15pm and daily from 3:15pm-4:00pm. There will not be any teacher meeting unless an appointment is scheduled.
- I must attend 3 of 5 parent meetings/parent trainings that will be held throughout the year at the Carrie Brazer Center for Autism, Inc.
- I must attend an Individual Educational Plan (IEP) within the first 90 days of the school year, and may request up to 1 more additional meeting within the year.
- I agree that my child must attend 7 of the 9 school scheduled field trips to teach my child appropriate socialization skills while learning to exhibit appropriate behaviors in various environments.
- I agree that my child must attend school on a regular basis. He/she is only permitted 3 unexcused absences and 5 unexcused tardies per every nine-week period. A tardy is considered arriving after 8:45 am. I agree that my child may only be excused early before 2:30 pm 3 times per nine-week period. I understand that any other tardy past 9:00am or any early dismissal before 2:30 pm is considered missing a ½ day of school and will be accumulated towards absences. (Special consideration will be made for those children who are extremely ill and a doctor's note must be provided for all days missed.)
- I agree that I will call/notify the Carrie Brazer Center by 8:30 am whenever my child will be tardy or absent each and every occurrence.
- I understand that The Carrie Brazer Center for Autism, Inc. follows a strict Gluten-Casein free diet and I agree that my child will abide by this diet during the school day. I will only send food for my child for lunch that is on the Gluten-Casein Free diet. This list of foods has been provided for you in the attached enclosure. Chickens, meat, rice, beans, cold cuts, etc, are all permitted. No candy, bread, milk and chocolate will be permitted on campus. (This is to ensure that all children on the diet are not tempted or endangered by foods they are restricted from consuming.) This includes birthday cakes!
- I understand that to ensure that my child is not lost and that he/she may be easily identified at all times, my child must wear his name tag and bright orange t-shirt everyday to school and while on fieldtrips.
- I agree to support my school, The Carrie Brazer Center for Autism, during the National annual walk-a-thon this year by walking on our team and wearing our school t-shirts rather than forming my own team! I will do my best to recruit as many friends and members of my family out to walk at the walk-a-thon to show support for this great cause.
- I agree I must participate in the planning of 7 of 10 meetings for our school's fundraisers. It will be the responsibility of each family to raise $500 minimum annually. If we cannot, we must make the contribution on our own. Or each family may volunteer 10 hours per $100 before and during the fundraiser or when needed throughout the year.
- I understand that The Carrie Brazer Center for Autism, Inc. reserves the right to affect the withdrawal of the child, if, in the judgment of its professional staff, the child presents a danger to him/herself or others or if the parent or guardian of the child becomes unreasonable and staff cannot come to mutual agreements of procedures and policies.

Initial Parent/Guardian _____

CARPOOL RULES

- **All students must be dropped off in the supervised area on the side of the building by the exit door.**
- **Stay in your car**. Teachers will assist children getting in and out of the car. Stay in the carpool loading/unloading line. Please do not park and walk your child(ren) through the carpool lines at drop-off or pick-up times.
- **Drop off time is 8:30-8:45 am. School begins at 8:45 am. After 8:45 am your child will be marked tardy. You must then park your car and bring your child through the front office.** An office staff will bring your child to the classroom. You will not be permitted to walk your child in directly or to speak with the teaching staff, as class would have already started and we do not want to interrupt the teaching process.
- **Pick-up time is 3:00-3:15 pm for all students 3rd grade and above and 2:00-2:15 for Kindergarten through 2nd grade. (Wednesdays at 2:15 for all students) If you arrive after dismissal you must then park your car and pick up your child(ren) at the front office**. An office staff will bring your child to you. You will not be permitted to walk directly into your child's classroom or to speak with the teaching staff, as teachers will be in their planning period from 3:15-4:00 pm and in parent/teacher conferences and we do not want to interrupt them.
- **Place your car in "park" and turn off the motor.**
- **Give your full attention to the job at hand. Do not use your cell phone at any time during carpool.**
- **Use extreme caution when leaving and entering the carpool area and exiting the center.**
- **All transportation changes must be in writing and given to our office manager. We will then notify the teachers.**
- **Any unfamiliar people must present a driver's license. NO EXCEPTIONS!**
- **Parents must sign in and out your child each and every day.**
- **Parent/teacher conferences & IEP meetings can be scheduled**: Wednesdays 2:15 pm-4:00 pm, and daily 3:15 pm – 4:00 pm.

AFTER CARE

- **After 3:00 pm (2:15 pm on Wednesdays) your child will be brought to after care. You will be charged $15 per hour for the entire hour of after care**. We will not pro-rate after care by the minute. You are welcome to take advantage of after care daily until 5:45 pm. If you are ever late after 6:00 pm, you will no longer be able to participate in after care services. All after care services must be paid in full by the end of each week.
- Please pre-arrange after care services with our front office manager so that your child does not need to wait in our carpool line unnecessarily for you.
- We offer a special after care rate of $150 per week until 5:45pm for pre-arranged services.

POLICIES & PROCEDURES FOR SUMMER CAMP, AFTER-SCHOOL and SATURDAY PROGRAMMING

I understand that I must abide by the following set of guidelines to enroll my child in After School, Saturday & Summer Camp 2020-21 Programs.

- All scholarships are for a ratio of 5-6 campers to one staff. If your child requires a lower ratio you will be required to pay the difference in cost. Please contact our Parent Liaison for more information.
- Families planning on taking vacations should alert the Center so that other children can make use of the scholarship during the time your child will not be with us. Campers will be permitted 2 unplanned absences.
- Parents will notify the Center by 8:15am whenever you child will be tardy or absent.
- Early care will be available 7:45-8:45am (pre-registration is needed). All children must be dropped off between 8:45 and 9:00am. The bus will leave for community-based outings at 9:00am. Parents who miss the bus will not be permitted to drop their child at the field site, unless pre-arranged 24 hours in advance. Furthermore, 3 tardies will be equivalent to one absence and will count towards the total unplanned absences.
- Children must be picked up promptly by 4 pm daily during camp days and Saturdays. After School will be available from 3:00-5:45 pm daily. The fee for this service is $15 per hour or $150 per week. Please pre-register your child for aftercare if you know that you will be using this service on a regular basis. Late pick ups will be charged $15 for any time after 5:45 pm and must be paid on the day of service. Children who are late on a regular basis will be suspended from services or withdrawn from program entirely, based upon judgment of professional staff! Any late pick-up after 4:15 on Saturdays or 6:15 during week is considered unreasonable, unless an emergency occurred on a 1 time basis. Repeated offense is total disregard of our staff.
- All campers must wear the orange CBC camp shirt every day & must also pack and extra orange CBC camp shirt in their backpacks.
- All Parents/Guardians of children enrolled in summer camp or summer school must attend summer camp orientation. Date to be announced later.
- I understand that The Carrie Brazer Center for Autism, Inc. reserves the right to affect the withdrawal of the child, if, in the judgment of its professional staff, the child presents a danger to him/herself or others or if the parent or guardian of the child becomes unreasonable and staff cannot come to mutual agreements of procedures and policies.

I understand that failure to comply with these guidelines may result in the dismissal from the program and/or the loss of my scholarship.

PARENT NOTIFICATION - PHYSICAL RESTRAINT PROCEDURES

There are instances when exceptional students enrolled in programs for the emotionally handicapped, severely emotionally disturbed and autistic as well as other Exceptional Student Education programs may exhibit behaviors that pose a threat to the safety of persons or property. When this occurs, the Parent will authorize the use of specific physical restraint techniques in order to prevent injuries to personal or destruction of property. These techniques, which include holding and escape techniques, minimize the risk of injury to the student being restrained, other students and the teacher. These procedures are not used as punishment.

The use of physical restraint techniques will be discussed as part of your child's IEP review and development process. Your participation in that process is welcomed and encouraged. Please acknowledge your receipt of this notification by signing below and returning a copy to the school. If you have any questions regarding this matter, please call your school at (305) 271-8790.

Parent Signature _____ Date _____

AGREEMENT FOR INSTRUCTION/CARE OF STUDENT

This agreement is made between The Carrie Brazer Center for Autism, Inc., Federal ID #26-1617177, ("the Center"), and _____ _____ Parent/Guardian, who resides at _____, _____ _____County, Florida, services provided to the child of Parent/Guardian ("Student")

RECITALS

A. The Center is primarily engaged in, but not limited to the business of providing special education, care, and therapy to children with autism and other like needs.
B. The Center has expended great efforts and large sums of capital cultivating its broad client base, trained staff of teachers and therapists, and business reputation.
C. The Center has expended great efforts and large sums of capital required to operate the business.
D. Parent desires to enroll Student in the Center. For the reasons recited above, and in consideration of mutual promises and covenants set forth below, the Center and Parent agree as follows:

SECTION ONE: MEDICAL CONSENT

In the event of an emergency situation and Parent cannot be contacted, Parent agrees, acknowledges and consents to the Center seeking medical attention on behalf of the Student. Parent further agrees, acknowledges and consents to any and all reasonably necessary diagnostic and radiological testing, deemed reasonably necessary medical treatment by any and all trained medical staff. Medical treatment includes, but is not limited to hospitalization, injections, anesthesia, and/or surgery. Parent further agrees to hold the Center harmless for any and all financial responsibilities incurred by Parent because of such medical treatment. Parent further agrees to hold the Center harmless for any and all complications, negligence, misconduct, which might result from such medical treatment/care.

I hereby give permission to the physician and/or health care provider selected by the staff at the Center the permission to order the necessary diagnostic tests, radiological tests, and any other necessary medical treatment for the health of my child and in the event that I cannot be reached in an emergency situation. I give permission to the physician/health care provider to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for my child as name above.

SECTION TWO: ASSUMPTION AND RELEASE

Parent acknowledges that the Center will use its best efforts in ensuring the safety of each Student. However, Parent understands and acknowledges that there is an inherent risk associated with the activities of a school. Parent hereby remise, releases, acquit, satisfy, and forever discharge for any and all causes of action, in law or equity, that Parent had, has or will have in the future until the end of time, against the Center, staff, employees, agents, officers, directors, and/or volunteers, from any and all liability, including physical and property damage, arising from Student's enrollment in program.

Parent acknowledges, agrees and consents that Parent's and/or Student's insurance bears responsibility and coverage in the event of an accident/injury to or caused by Student, by the Center, or by employee. Parent agrees and consents to hold the Center harmless for any and all injuries caused by a volunteer of the Center.

I understand that I, as the parent/legal guardian of the child do hereby expressly acknowledge that the activities involved in field trips and on site involve risks, and I do hereby voluntarily assume any and all risk including, but not limited to injuries to my child and/or my child's property, which may result from participation from these events. I hereby acknowledge, agree and consent that my personal insurance bears primary responsibility and coverage in the event of an accident/injury to or caused by my child irrespective or negligent act or omission by the Center, its staff and volunteers. I hereby release the Center, its staff, employees, agents, officers, directors, and volunteers, from any and all liability, including negligence, arising from this program. I also understand that this organization offers low cost programs otherwise not available to assist children with developmental Disorders/Autism. In return, I individually and as the legal guardian of the child named above, do hereby release and agree to hold harmless the Center, its staff, employees, agents, officers, directors, and volunteers, irrespective of any negligent act or omission by the Center staff, employees, agents, officers, directors, and volunteers.

SECTION THREE: CONSENT FOR TRIPS

Parent hereby consents to any and all field trips organized by the Center for the Student. Parent gives permission and consent Student to participate in any and all activities Parent further acknowledges that said field trips (on-site and away) may involve a measure of risk. Parent voluntarily, knowingly and without duress or coercion assumes any and all risks including, but not limited to, injuries to child's person and/or property. I hereby give my permission and consent for the above-named child to participate in all activities and field trips and to be transported by Carrie Brazer and/or the staff and volunteers of the Center in personally owned, leased and/or contracted transportation.

SECTION FOUR: TRANSPORTATION CONSENT & INDEMNIFICATION

Parent acknowledges consents and holds the Center and individuals harmless for any and all accidents/injuries arising out of the transportation of child by Carrie Brazer, employees, and/or volunteers of the Center, in personally owned, leased and/or contracted transportation.

SECTION FIVE: TUITION PAYMENTS

Parent acknowledges that tuition and fees are to be paid by the 1st day of each month. After the 5th day of the month a late fee of 1.5% will be assessed monthly. If Outside Contributions of any kind are late, suspended or withdrawn, parent agrees to pay center within 5 days of expected payment from Outside Contributions. For example, McKay scholarships payments are due Sept. 1, Nov. 1, Feb. 1 and April 1 of each year payable to the parent to be endorsed to the school. (The checks are traditionally received at the school on the last Thursday of the prior month.) If payment is not received for any reason whatsoever by the Outside Contribution Source parent is responsible for said timely payment. If the Outside Contribution Payment is made after the Parent pays on behalf of the Outside Contribution Source, the School will reimburse parent for the amount paid. Upon of receipt of check payment from Outside Source to School, Parent agrees to endorse said payment to the Carrie Brazer Center for Autism within 48 hours of receipt (approximately: Sept. 1, Nov.1, Feb. 1 and April 1 - McKay). It is Parents sole obligation to endorse said check and pay any and all reasonable fees associated with securing the endorsement of same within the 48 hour period. The center reserves the right to withdraw student if parent fails to comply with the above said payment terms and parent shall be responsible for a 1.5% monthly finance charge until warrant/check is endorsed. Parent further agrees that should it be necessary to use the services of an attorney and/or collection agency to collect its bills for any services rendered by the Center, Parent shall be responsible for said fees, including but not limited to, attorney fees, court costs, and any other costs associated with said services.

It is essential that the parent whose name is on the scholarship check be the individual that endorses the check when received by the private school. (s. 1002.39(9)(f), F.S.) Under law, power of attorney cannot be given from the parent to the private school. (s. 1002.39(9)(f), F.S.) In addition, checks should not leave the possession of the private school and parents must come to their child's respective school to sign the checks.

Initial Parent/Guardian _____

SECTION SIX: DEPOSITS & FEES

Parent understands that the Center hires staff and coordinates small classroom size based upon enrollment for school; accordingly any and all annual tuition payments are non-refundable. Moreover, any payments not yet made (pursuant to an installment tuition payment plan) are due and owing (on the required dates), even if the Parent removes the child from the Center. If the child receives the McKay Scholarship and for whatever reason the McKay Scholarship does not pay for services rendered by the Center, the Parent is responsible for the amount uncollected from the McKay Scholarship.

Parent acknowledges and understands that all other programs and activities are preplanned and prepaid by the Center. Therefore, all fees and deposits are non-refundable. If Parent must cancel a program, including but not limited to, Super Saturday, teacher workday, camp day, School day, cognitive, speech, music, chiropractic, massage or occupational therapy sessions or any and all other services provided by the Center, Parent must provide the Center at least twenty-four (24) hours notice prior to scheduled activity/program. Parent may reschedule class/session, if applicable; however Parent will receive no refund.

SECTION SEVEN: CANCELLATION POLICY:

No refunds will be given for absences or withdrawals for any reason(s) whatsoever even if the student has not yet attended classes.. Withdrawal from school must be in writing and received no later than 8 weeks prior to the last day of attendance/ withdrawal. The Carrie Brazer Center shall not refund any unused tuition and parents shall remain liable for the full annual tuition and shall continue to make agreed upon payment(s) even if the child has had not begun classes or has been withdrawn from the school for any reason whatsoever, without right of set-off. [For purposes of this Agreement the term "for any reason whatsoever" shall include but not be limited to dissatisfaction with school, lack of progress or improvement of child, dissatisfaction or any claim or allegation of negligence of any kind from any of the center's employees and/or staff, change of staff including change of classroom teacher or aides, classroom change of location or size and change of teacher to child ratio, change of location of facility, change of or lack of supplemental services (i.e., speech, occupational and physical therapy, music, yoga, horse-back riding, vocational services, community based outings)]. Additionally, Parent understands that this contract is for a full school year agreement from August through June and parent is responsible for full annual payment in the event that Outside Contributions (i.e., McKay scholarship, corporate tax scholarships, grants or other outside financial assistance) may be terminated, decreased or withdrawn, for any reason whatsoever. By way of example, if the child is withdrawn prior to the completion of the school year and any Outside Contributions are withdrawn/decreased, the parent remains liable for the entire annual tuition plus any additional charges for the difference between the tuition and outside contributions agreed upon as set forth above. Additionally, parent is understands that it shall remain liable for any and all budget cuts throughout the year from the McKay scholarship program or any other Outside Contribution. Parent agrees that the School shall continue to charge the Parents account/credit card as per this Agreement (and as per the billing dates for both the tuition and tuition difference) as if the child remains enrolled in the program. Any and all Outside Contributions shall be due on the day the Outside Contribution would have been paid to the Center but for the withdrawal of the Student.

SECTION EIGHT: WITHDRAWAL OF STUDENT

The Center reserves the right to effect the withdrawal of a Student (from an activity or school) if, in the judgment of its professional staff, the student posses a danger to him/herself, or others or the Center staff believes the Parent/guardian has become unreasonable or unwilling to cooperate or will not abide by policies or procedures. Withdrawal from school by parent must be in writing and received 4 weeks before the last day of scheduled attendance.

SECTION NINE: TERM

This agreement is effective immediately on being signed by both me and the Center. The term of this agreement shall continue and survive for the later of one (1) year or full school year from the termination of my enrolment. THIS PROVISION SHALL SURVIVE THE TERMINATION OF THIS AGREEMENT.

SECTION TEN: GOVERNING LAW

This Agreement shall be construed in accordance with and shall be governed by the laws of the State of Florida, and venue of any action hereunder shall lie solely with the courts in and for Miami-Dade County, Florida, to which jurisdiction each of the parties agrees to submit for the purposes of any litigation involving this Agreement. THIS PROVISION SHALL SURVIVE THE TERMINATION OF THIS AGREEMENT.

SECTION ELEVEN: ATTORNEYS FEES AND COSTS

In the event a dispute arises between the parties under this Agreement, and suit is instituted, the prevailing party shall be entitled to recover costs and attorney's fees from the non-prevailing party. As used in this agreement, costs and attorney's fees include any costs and attorney's fees in any appellate proceeding. THIS PROVISION SHALL SURVIVE THE TERMINATION OF THIS AGREEMENT.

SECTION TWELVE: ABILITY TO BIND

Parent shall not have any right to bind the Center, to transact business in the Center's name or on behalf of the Center, in any matter or form, or to make any promises or representations on behalf of the Center. In the event of such activity, Parent agrees to indemnify Center, including but not limited to, attorneys fees, court costs, and any and all other costs associated with said litigation.

SECTION THIRTEEN: VALIDITY

This agreement is intended to be a valid contract under Fla. Stat. § 542.335. If a court of competent jurisdiction finally determines any part of this agreement to be unenforceable, then the remainder of this agreement shall be severed from the agreement and shall be enforceable. If a court of competent jurisdiction finally determines that my noncompete obligations under this agreement are unreasonable in time or geographic area, then the court may reduce the term of years or the geographical range, or both, so as to be enforceable.

SECTION FOURTEEN: TYPEWRITTEN OR HANDWRITTEN PROVISIONS

Handwritten provisions inserted into this Agreement and typewritten provisions initialed by both parties shall control over any and all conflicting typewritten provisions.

SECTION FIFTEEN: COMPENTENCY

I am competent to enter into this binding agreement. I execute said agreement voluntarily, without any coercion, duress, or undue influence.

_____ _____ _____

Print – Parent/Guardian Signature Date

Sworn and subscribed before me this __ day of _____ , 20___.

By _____ Personally known: __ _____ Produced Identification:
Driver's License # _____

_____ _____ Date: _____

Print- Notary Name Notary-Signature

State of:_____ Seal:

Client Rights and Responsibilities, and Consent for Treatment

Client Name: _____ Date: _____

As a potential client of the Carrie Brazer Center for Autism, I understand that I am assured humane and dignified treatment at all times and the following rights, and I agree to the following responsibilities.

Rights:

1. Right to refuse and/or terminate treatment at any time.
2. Right to informed consent.
3. Right to confidentiality whereby the information revealed by me during treatment will be kept strictly confidential (understanding that any pertinent information relative to my care will be documented in a The Carrie Brazer Center for Autism contact record) and will not be revealed to anyone without my written authorization. The law provides the following exceptions to this provision.
    a. If the Carrie Brazer Center for Autism has knowledge of client's intent to harm self or others.
    b. If the Carrie Brazer Center for Autism has knowledge of child abuse, neglect or exploitation.
    c. If the Carrie Brazer Center for Autism receives a court-order to the contrary.
    d. If client enters into litigation with the Carrie Brazer Center for Autism
    e. If medical emergency necessitates disclosure.
    f. If the Carrie Brazer Center for Autism has knowledge of client's intentional spreading of communicable disease.
4. Right to request second opinion.
5. Right to treatment without regard to race, color, sex, age, religion, national origin, disability or sexual orientation.

Parent/Legal Guardian/Client Responsibilities:

1. To keep predetermined appointment and to notify the Carrie Brazer Center for Autism at least 24 hours in advance of canceling or rescheduling an appointment.
2. To participate and follow agreed upon treatment.
3. To maintain confidentiality pertaining to group therapy, when applicable.
4. To assume responsibilities for payment of the assessed and agreed fees for services.
5. To inform the Carrie Brazer Center for Autism of any change in address and phone numbers.

Consent for Treatment:

I understand and voluntarily agree to the above, and I authorize evaluation and/or treatment by the Carrie Brazer Center for Autism. I understand that this consent can be repealed in writing at any time during the treatment period.

Name Parent/ Guardian: _____ Date: _____

Signature _____ Date: _____

The Carrie Brazer Center For Autism
A Positive Discipline School
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Consent for Release of Information

Therapist _____

Client's Name: _____ Date of Birth: _____

I, undersigned, voluntarily request and authorize the personnel at the Carrie Brazer Center for Autism to exchange with/obtain from/release to the party I have indicated below the information contained in my clinical and medical record. I authorize the Carrie Brazer Center to exchange, release or obtain information verbally/in writing/both in writing and verbally. I understand that my health information may be protected by the Federal Rules (HIPAA) for privacy of Individually Identifiable Health Information (45 CFR parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient records (42 CFR Chapter, part 2), and/or the State laws.

I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations.

Person/Organization receiving information from or communicating information to the Carrie Brazer Center for Autism include:

Name: _____ Phone: _____

Agency/Organization: _____

_____

Purpose of Release: ABA Therapy information _____

_____

_____

Print Name:: _____ Date _____

Signature: _____ Date: _____

Relationship: ☐ Parent ☐ Guardian

_____ (initial) I choose to decline the invitation to authorize communication between my therapist and other members of my medical team (i.e., primary care physician, psychiatrist, other current and/or past therapists).

_____(Initial) This consent is valid until my written request to rescind this authorization or at the termination of active treatment at the Carrie Brazer Center for Autism.

The Carrie Brazer Center For Autism
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Notice of Privacy Acknowledgement

Client's Name: _____ Date of Birth: _____

Social Security Number: _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessment and physician/non-physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of health information. I understand that this organization has right to change it **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the **Notice of Privacy Practices**. (Do we have a more complete description of our Notice of Privacy Practices?)

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or other healthcare operations. I also understand that you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Parent/Legal Guardian Signature: _____Date:_____

The Carrie Brazer Center For Autism
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Notice of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Responsibilities
the Carrie Brazer Center for Autism is required by law to maintain the privacy of your protected health information in our custody. We must provide you with notice of our legal duties and privacy practices with respect to your health information. We must also follow the terms of this notice.

How the Carrie Brazer Center for Autism Uses and Safeguards your Health Information
If you are a Medicaid/MediKids recipient, we use your health information to pay for your health services and to operate the Medicaid program. We may also use your health information to tell you about treatment alternatives or other health-related benefits and services.

The following are some examples of how we may use your health information:

- Your doctor may send us a claim to pay. The claim includes information that identifies you and the type of care you received.
- We may share your information with a company that reviews hospital records to check on the quality of care that you received.
- We may send appointment reminders for Child Health Check-Up services.

The Carrie Brazer Center for Autism may also use and disclose your health information as permitted by law, such as:

- To entities outside the agency for purposes directly connected with the administration of the State Medicaid plan.
- In responding to public emergencies, access to your health information may be granted to persons or agency representatives who are subject to standards of confidentiality comparable to those of the Carrie Brazer Center for Autism.
- Where disclosure would assist in determining eligibility for benefits, amount of medical assistance payment or otherwise assists the agency in the administration of the Medicaid program.
- To the confidential Florida abuse hotline in order to report abuse, neglect and/or domestic violence as per criteria and conditions imposed on the agency by law.
- For health oversight activities and/or administration of the Medicaid program, such as inspections, investigations, and audits.
- To conduct research to benefit the Medicaid program.
- For purposes of treatment, payment, or our operations and as otherwise required by law.

Other uses or disclosures of your protected health information require your or your personal representative's written authorization. We will not use or disclose your protected health information for marketing purposes without your written authorization and we will not sell your protected health information without your written authorization. We also are prohibited by law from using or disclosing genetic information for insurance underwriting purposes. At any time, you may revoke authorizations in writing. If you cannot give your authorization due to an emergency, we may release your health information if it is in your best interest.

Your Health Information Rights

You have the following rights with respect to your protected health information:

- To see or obtain a copy of your health information that is maintained by the Carrie Brazer Center for Autism. We may not be able to provide health information that includes psychotherapy notes, is part of a legal case, or is otherwise excluded from disclosure by law.
- To request that we amend health information we maintain that you believe is incorrect or incomplete.
- To request a list of disclosures we have made of your health information. The list may not include disclosures authorized by you, disclosures for treatment, payment and health care operations, or other disclosures permitted by law.
- To request that we contact you at a different address or phone number, if contacting you about your health information at your present location would endanger you.
- To request that we limit the use and disclosure of your health information. We are not required to agree to your request.
- To request another paper copy of this notice.
- To opt-out of fundraising communications from us should the Carrie Brazer Center for Autism ever engage in fundraising.
- To receive a notification from us following a breach of your unsecured protected health information.

Contact Information

If you have questions or would like additional information, you may contact the Carrie Brazer Center for Autism At (305) 271-8790. If you believe your privacy rights have been violated, complaints should also be directed to Filing a HIPAA Complaint to Carrie Brazer.

If you believe your privacy rights have been violated by Carrie Brazer or one of its employees, you may file a complaint with AHCA and/or the Secretary of the Department of Health and Human Services at the addresses below. You will not be retaliated against for filing a complaint.

Privacy Officer
Agency for Health Care Administration
Mail Stop 4
Tallahassee, Florida 32308
(850) 412-3960

Secretary
Department of Health and Human Services 2727 Mahan Drive,
200 Independence Ave. SW
Washington, D.C. 20201
(800) 368-1019