



## **ZELEXA**

31229 Plymouth Road  
Livonia, MI 48150

Phone: (734) 466-5150 Fax: (734) 466-5160

### **Welcome Packet**

We would like to welcome you to Zelexa Autism Services! We are excited that you have chosen Zelexa as your child's ABA provider. If you have any questions please feel free to call us at (734) 466-5150.

#### **Items to bring:**

- \_\_\_ Backpack
- \_\_\_ Packed lunch, 1 morning snack, and 1 afternoon snack  
*(Label items, for example am snack, lunch, and pm snack)*
- \_\_\_ Extra set of clothes in the backpack enclosed in a Ziploc bag with initials
- \_\_\_ 3 packages of wet wipes in the backpack with initials *(sensitive, non-scented)*
- \_\_\_ 5-6 Pull-Ups/diapers *(if applicable)*

\*For Center-based therapy we recommend you arrive 10 minutes prior to start & departure time.

#### **Lunch Policy (For Center-Based Therapy)**

You should send your child with a lunch and two snacks each day. We ask that the lunch and snacks be ready to eat straight from the lunch box. We will pack up uneaten portions of the lunch and snacks whenever possible to allow you to see how much your child is eating while at the center.

#### **Inclement Weather Policy**

Zelexa's #1 priority is providing the best service to our clients. Our weather policy will be such that if the local school district is cancelled, then Zelexa will also be closed. If the school district opens on a delay, our treatment centers and in-home therapy services will also open at the same time as the school district. Zelexa will also determine if a Saturday make-up day is possible for those clients missing the day of therapy.

\*We do not follow the school district's holiday schedule.

In addition, please make sure you complete the enrollment packet forms and schedule form prior to your start date.

Sincerely,  
**Zelexa Team**



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## **Specialized Services Service Agreement**

**Client Name:**

**Date:**

**Parent(s):**

### **Parent Regulations**

This is an agreement between the above listed parent(s) and Zelexa (ZELEXA).

1. An emergency contact form must be completed and accurately maintained on file at all times.
2. Parents are responsible for immediately notifying ZELEXA of any concerns regarding the program, ZELEXA staff members, etc. so that these concerns can be addressed.
3. Parent(s) must participate in agreed upon parent project(s). Parents are also required to attend meetings during a regularly scheduled session at the facility location.
4. Parent(s) is/are responsible for notifying staff and consultant of any dietary restrictions.
5. Coordinators must be notified of any and all alternative therapies.
6. Parents are to only observe and discuss their child's program with ZELEXA staff. Due to our respect of confidentiality (HIPPA) requirements for the children participating in our programs, your child will not be discussed with other parents, and we will not discuss other children with you.
7. Sessions can only take place if the child is healthy. In the event of illness (e.g., fever, green mucus in the nose, nausea, vomiting, and diarrhea) the parent(s) must contact ZELEXA as soon as possible and sessions for that child will not take place. The child is to be symptom free for 24-hours before services can resume.
8. Parents must complete all required paperwork in a timely manner.
9. Due to the nature of delivering services in the home setting, it is the family's responsibility to secure the supplies necessary to complete therapy sessions. The coordinator will discuss what items are necessary for you to secure during your results meeting, as well as during your team meetings. The list of necessary items may or may not include access to a computer and Internet.
10. ZELEXA closes for some holidays, conferences, training seminars, and staff training/planning days. See the ZELEXA calendar for specific dates.



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Parent/Guardian Initials: \_\_\_\_\_

Your child’s treatment program and progress notes/graphs are stored on a secure server so that a BCBA can review them regularly. If you are unable to secure these items then we will not be able to deliver services, as therapy materials are a necessity to providing services. ZELEXA staff is required to clock in and out by phone or Internet from your home. Please provide one method for our staff so that we will be accurate on times and dates in which services are provided in your home.

Absences, late arrivals, and early departures will be tracked closely. If there is a pattern, we will set a more realistic schedule for your child. We are requiring that you notify us in advance of planned absences, late arrivals, or early dismissals so that we are able to adjust staff schedules or serve a client on our growing waiting list. If we receive less than a 24-hour notice, we will not be able to adjust accordingly. Last, if consecutive sessions are missed and the family has not communicated with ZELEXA, this will be considered treatment abandonment.

Parent/Guardian Initials: \_\_\_\_\_

11. I understand that in order for any correspondence to take place with my insurance company, I must obtain a diagnosis code in writing from my child’s primary physician and I will provide a copy of the diagnosis for my child’s file here at Zelexa. Diagnosis codes will be included on invoices with CPT codes ONLY if provided by the child’s primary physician.

12. I understand for Zelexa to bill my insurance for services, ZELEXA will need to share any information regarding services with my insurance company.

\_\_\_ I consent for Zelexa to provide any documentation to the insurance company as requested by the insurance company or the parents.

\_\_\_ I am a private pay client and do not consent to Zelexa providing any information to my insurance company.



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### 13. Photography Consent:

- \_\_\_ I give permission for Zelexa to take photographs of my child (children). I understand that the photographs of my child (children) will be included in marketing materials by Zelexa. I understand that my child may be included in photographs with other children, and I give permission for any photo that includes my child to be shared through any marketing channel Zelexa chooses. I understand that this is a voluntary agreement and will not affect my child's therapy program and can be changed at any time.
- \_\_\_ I do not give permission for Zelexa to take photographs of my child. I understand that this is a voluntary agreement and will not affect my child's therapy program and can be changed at any time.

*Parent/Guardian Initials:* \_\_\_\_\_

14. A parent or guardian must remain at home at all times while a therapist is in the home providing services. If the parent or guardian wants or needs to leave, then the ZELEXA employee will leave the house as well. If the parents choose to leave a guardian in charge, the Guardianship agreement must be completed, sign and submitted to the coordinator prior to leaving another adult in charge.
15. Due to safety reasons, ZELEXA therapists will not be allowed to conduct therapy sessions in the pool (or any other body of water). Additionally, sessions are not to be conducted in a busy street. Sessions should occur in the home or on the property of the home as long as there are no safety risks involved. Special permission can be granted for sessions to be conducted in the community setting but parents will need to transport the child and remain in the community setting while sessions take place.
16. ZELEXA employees are under an employment agreement with Zelexa. Therefore, ZELEXA employees cannot enter into a separate employment agreement or arrangement for services or any other services with the family. If an employee enters into such an agreement, the employee will be held accountable and the family may be involved in the legal proceedings.
17. I understand that the program requirements and structure are subject to change including but not limited to, changes that may affect my child's eligibility. If such changes are made parents will be notified in writing ASAP.

*Parent/Guardian Initials:* \_\_\_\_\_



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## Staff Responsibilities

1. ZELEXA will ensure that your child receives the specified number of hours of intensive behaviorally analytic treatment, excluding holidays, child illness, client vacation(s) or emergency situations, or your account will be credited.
2. ZELEXA is responsible for the supervision and on-going training of all staff therapists. Consultants monitor programs, evaluate effectiveness, make programmatic changes/modifications and provide training to the therapists.
3. ZELEXA is responsible for but is not limited to; conducting team meetings, developing programs, implementing programs, monitoring and updating programs, and the development of a data collection system and monitoring of that system.
4. ZELEXA adheres to the Behavioral Analysis Certification Board Guidelines for Responsible Conduct, therefore any information related to a specific client will remain confidential at all times. ZELEXA embraces training of professionals. Hence, your child's confidentiality will be protected in any in vivo or videotaped sessions of your child that is used for training purposes. Protection of confidentiality also applies to photography or video taken by ZELEXA, their Assessment and their work applies to photography or video taken by ZELEXA, their Assessment and their work samples, to be used for the purposes of marketing material on behalf of ZELEXA No form of identification will ever be used; therefore, your child's name will not be associated with the product info. Lastly, data from your child's prescribed treatment program may be used in general research to benefit autism intervention and will not have information to reveal the identity of your child. Any research involving intervention outside of consultant recommendations will be reviewed by the consultant's and parents and an additional release of consent will be signed.
5. ZELEXA is responsible for notifying, in writing, the parent(s) of any service delivery changes.

**I have read this service agreement and agree to abide by its terms and conditions.**

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of ZELEXA Representative

\_\_\_\_\_  
Date



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## Guardianship Agreement

**Client Name:**

**Date:**

**Parent(s):**

ZELEXA contract outlines that a parent or guardian must remain at home at all times while a therapist is in the home providing services. If the parent or guardian wants or needs to leave, then the ZELEXA employee will leave the house as well.

ZELEXA defines a guardian as:

- An individual who is 21 years old or older
- A competent individual who has the ability to make sound decisions and act on the child's
  - Medical needs
  - Daily needs ☑
  - Transporting the child
  - Is not under the influence of illegal substances, or over the legal alcohol limit
- This individual is aware of and has been given permission to make decisions about the **child's**

By signing below (we) \_\_\_\_\_, the parents of \_\_\_\_\_ agree to and understand the above requirements need to be met in order for sessions to be conducted while a parent is not present.

We are naming \_\_\_\_\_ as the temporary custodial guardian while Zelexa conducts therapy sessions with my child. If any of the above requirements are suspected or not met by the temporary custodial guardian, then Zelexa will inform the parents as soon as possible, in order to resolve the matter. This agreement is approved by all parties and is valid until the custodial parents inform Zelexa in writing otherwise. Upon written notice the agreement is void then and there.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date





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## Patient Bill of Rights and Responsibilities

**Client Name:**

**Date:**

**Parent(s):**

ZELEXA is dedicated to helping children with developmental disabilities achieve their potential in family, community and school life. We care about the dignity and welfare of all who receive services from us.

Although these rights are written for the patient, in most cases they also apply to the patient's parents or legal guardians. We expect staff, patients, families and visitors to act in a reasonable and responsible way at all times.

If you have a concern about any of these rights or responsibilities, you may discuss it with the staff involved, their supervisor or our Clinical Director. If you are still concerned, you may also speak with the executive director's office by coordinating with the Clinical Director.

### Your Rights:

- You have the right to considerate, respectful care at all times and under all circumstances, with recognition of personal dignity.
- You have the right, within the law, to personal and informational privacy.
- You have the right to expect reasonable safety insofar as the center's practices and environment are concerned.
- You have the right, within the law, to personal and informational privacy.
- You have the right to verbal and written communications.
- You have the right to refuse treatment to the extent permitted by law. When the refusal of treatment by a patient, or their legally authorized representative, prevents the provision of appropriate care in accordance with professional standards, the relationship with the patient may be terminated upon reasonable notice.
- You have the right to expect that Zelexa staff is competent to obtain and interpret information in terms of your needs and to have an understanding of the range of treatment needed.
- The family and/or guardian of patients have the right to be involved in the patient's continuing care.

*Parent/Guardian Initials:* \_\_\_\_\_





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- You have the right to assistance for conflicts regarding services rendered. If applicable, the Zelexa provider should always be made aware of any conflict. If resolutions of conflict cannot be achieved with the patient/family through the professionals involved, the patient/family has the right to request a meeting with the Clinical Director who has the ultimate authority in resolving conflicts.

### **You have the responsibility to:**

- Provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to your child's health.
- Follow treatment plans recommended by Zelexa practitioners.
- Be responsible for your actions if you refuse treatment or do not follow the practitioner's instructions.
- Assure that the financial obligations of your child's health care/service are fulfilled as promptly as possible.
- Be responsible for keeping your insurance information/coverage/policy numbers up to date with Zelexa.
- Be considerate of the rights of other patients and Zelexa staff for assisting in the control of noise and number of visitors.
- Be respectful of the property of the other persons and Zelexa treatment facility

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Signature of Parent

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Date



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## Notice of Privacy Practice

**Client Name:**  
**Parent(s):**

**Date:**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION.

### PLEASE REVIEW CAREFULLY

#### **Medical Information:**

Zelexa understands that your treatment information is personal to you, that is why we are committed to protecting your information. A record is created for you when you first come in. This record has information of the services that your child receives. You have the right to limit the disclosure to insure proper treatment and payment.

#### **Disclosures of Medical information:**

The following are descriptions of different ways we may disclose your information. Not every disclosure is listed; however we are permitted to use this information that may fall in one of these categories.

**Coordination of Services:** We may disclose your child's information to another service provider if you have signed a release of records consent.

**Emergency Situations:** We may disclose basic information about your child to provide emergency medical treatment in case of an emergency. This could be doctors, nurses or other emergency staff.

**Payment:** We may disclose information about your child to an insurance company so we may Zelexa bill and collect on the services that your child received.

**Individuals Involved in Your Child's Care:** We may release treatment information about your child to family members or family friends who are involved in your child's treatment.

**As Required by Law:** We will disclose medical information about your child when required to do so by federal, state, and local law.

**Healthcare Audits:** We may disclose this information to an audit agency for activities authorized by the law. These audits may include investigation, inspections, and credentialing



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## Notice of Privacy Practice

### Your Rights:

**The Right to Records:** You have a right to your child's treatment information. You can do this by calling ZELEXA 's Administrative Department. An appointment will be set for you to come in and review them. You may also have copies your records, although we will need a 30-day notice to collect them for you.

**Restriction Right:** You have the right to restrict the disclosure of your child's treatment information. You also have the right to limit the information we disclose about your child to someone involved in your child's care, such as family.

To request restrictions, you must make the request in writing to outline what information you want limited and whom you want the information limits to apply towards (Please see Medical Release Form).

**Right to Request Confidential Communication:** You have the right to request that we communicate your child's information to you in a certain way or at a certain location. For example, you can ask us to only contact you at work.

To request confidential communications, the request must be in writing and include how we may get in touch with you. We will try to accommodate all reasonable requests.

**Right to Have a Copy of the Privacy Notice:** You have the right to have a copy of this notice. You may ask us for this copy at any time.

**Changes to this Notice:** We reserve the right to change this notice. We reserve the right to revise without prior notice and you will receive a copy.

**Complaints:** If you believe that your privacy has been violated, you may file a complaint with our office.

**Other:** If you provide us with permission to use or disclose information about your child you may revoke it at any time. This must be in writing with your written authorization. You understand that we are unable to take back any disclosures that were already made with your permission.

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Signature of Parent

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Date



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## Medicine Authorization Form

Client Name: \_\_\_\_\_

Dates Updated: \_\_\_\_\_

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

<b>Medication:</b> _____	<b>Effective dates:</b> _____ to _____	<b>Office use only</b>
Dosage Amt: _____	Please Administer until <input type="checkbox"/> Regimen complete <input type="checkbox"/> Otherwise notified	<input type="checkbox"/> Master list
When/Frequency: _____		<input type="checkbox"/> Admin notified
How to deliver: _____		<input type="checkbox"/> Team notified
Side effects to be aware of: _____		
Any other special instructions: _____	Parent Signature to Authorize	
_____	_____	
_____	BI representative	

<b>Medication:</b> _____	<b>Effective dates:</b> _____ to _____	<b>Office use only</b>
Dosage Amt: _____	Please Administer until <input type="checkbox"/> Regimen complete <input type="checkbox"/> Otherwise notified	<input type="checkbox"/> Master list
When/Frequency: _____		<input type="checkbox"/> Admin notified
How to deliver: _____		<input type="checkbox"/> Team notified
Side effects to be aware of: _____		
Any other special instructions: _____	Parent Signature to Authorize	
_____	_____	
_____	BI representative	

<b>Medication:</b> _____	<b>Effective dates:</b> _____ to _____	<b>Office use only</b>
Dosage Amt: _____	Please Administer until <input type="checkbox"/> Regimen complete <input type="checkbox"/> Otherwise notified	<input type="checkbox"/> Master list
When/Frequency: _____		<input type="checkbox"/> Admin notified
How to deliver: _____		<input type="checkbox"/> Team notified
Side effects to be aware of: _____		
Any other special instructions: _____	Parent Signature to Authorize	
_____	_____	
_____	BI representative	

Staff members of Zelexa are authorized to seek emergency medical treatment on behalf of my child if neither parent can be reached.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date



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## Emergency Information Form

*Note: This form should be updated when starting and each semester.*

Child Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Parent(s): \_\_\_\_\_

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

Mom's Phone #: \_\_\_\_\_

Dad's Phone #: \_\_\_\_\_

Mom's Email: \_\_\_\_\_

Dad's Email: \_\_\_\_\_

### Allergies

Allergic to: \_\_\_\_\_

Response: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Response: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Response: \_\_\_\_\_

### Seizures

Seizures?  Yes  No

If yes, please list your requests as it relates to seizures:

### WHO TO CONTACT:

1<sup>st</sup> Person: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone: \_\_\_\_\_

2<sup>nd</sup> Person: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone: \_\_\_\_\_

3<sup>rd</sup> Person: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone: \_\_\_\_\_



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## **Benadryl Permission Form** *(Optional)*

### **Client Name:**

I give permission for my child's therapist, consultant, or team member of Zelexa to administer the appropriate dose of Benadryl, as indicated on the bottle of medicine, to my child in the case of suspected insect bite(s) or allergic reaction.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

### **Authorization for Medical Emergency Treatment**

Staff members of Zelexa are authorized to seek emergency medical treatment on behalf of my child if neither parent can be reached.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



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## Authorization to Pick Up Form

**Client Name:**

Parent has authorized the following people to pick up their child:

1. \_\_\_\_\_ Relationship to the child: \_\_\_\_\_

Contact Info: \_\_\_\_\_

2. \_\_\_\_\_ Relationship to the child: \_\_\_\_\_

Contact Info: \_\_\_\_\_

3. \_\_\_\_\_ Relationship to the child: \_\_\_\_\_

Contact Info: \_\_\_\_\_

Any other special pick up instructions:

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date