

FINANCIAL AGREEMENT

1. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family where I am listed as the responsible party. I hereby agree to pay my insurance deductible and/or co-payment as services are provided. If for any reason there is a balance due on my account, I agree to pay promptly upon receipt of the monthly statement. I understand that the Kovner Center does not initiate billing to an insurance that is **secondary**. They only bill to the primary insurance company. I am responsible for activating & billing any secondary insurance coverage and for obtaining any necessary pre-authorization &/or treatment plan submission requirements for secondary insurance coverage. It is also my responsibility to review the Explanation of Benefit (EOB) forms I receive from my insurance so I can track insurance payment for services rendered.
2. I understand that my insurance claims will be sent electronically via computer modem and the Kovner Center will direct the insurance claim to my insurance company electronically where it will be reviewed by any insurance company staff assigned to review claims. I understand that my insurance company will obtain information listed on the insurance claim about my diagnosis and the dates of my mental health treatment sessions. By my signature below, and as recorded on the HIPAA consent form, I am giving Psych and Psych Services the Kovner Center permission to release all data necessary to my insurance company to determine eligibility and to process my insurance claim electronically. I realize that my insurance company may choose to make this information available to other entities, including other insurance companies. Furthermore, I authorize that payment of mental health/chemical dependency benefits be made to the Kovner Center under its corporate name (Dunwoody Psychology, Inc.). Any questions that I have about confidentiality can be answered in the Notice of Privacy Practices found in the waiting room (abridged version is given to all clients). I have also signed the HIPAA acknowledgement form and understand my client rights and the rules regarding release of Protected Health Information. I have been informed that I can ask the Privacy Officer any questions regarding confidentiality of records, the complaint procedure, or other matters pertaining to my review of my record.
3. Although I have requested the office to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.
4. ***Certain special services (e.g. school psychological evaluations, report writing, some types of testing, court-ordered treatment/evaluation) are often not covered by insurance. It is the clients responsibility to determine what services are and are not covered by their health insurance. If you are being seen for any services other than psychotherapy it is strongly recommended you call your insurance carrier to verify coverage.**
5. ***If you become involved in any legal matter that requires your therapist to testify in Court, or to prepare reports for your attorney or the Court, you will be charged \$200.00 per hour for these special services. For any court appearances for witnessing treatment or psychological evaluation, the Kovner Center requires a \$1600.00 retainer to cover one day of services. Each additional day will require an additional \$1600.00 to be paid in advance of these services. These services will not be billed to insurance as they are not mental health therapy/evaluation services. YOU WILL NOT NECESSARILY BE REMINDED OF THESE SPECIAL CHARGES.**
6. I understand that charges will be added to my account for professional services rendered by my therapist (i.e., phone contacts over 10 minutes, preparation of special forms, reports, court time, etc.). The fee for these services is \$175.00/hour and is not covered by insurance. The client will be reminded prior to the delivery of these services of the additional charges.
7. I am aware that I will be charged \$50.00 for each appointment that I miss or cancel less than 48 hours in advance. I agree to pay this amount and I understand that this charge cannot be billed to my health insurance carrier. If I request a copy of my records I will be charged the rates listed in the Office Policies document I received.

I have read and understand the financial agreement as detailed above. By my signature below I agree to abide by the terms of the financial agreement, fully understand the release of information to my insurance carrier, and agree to make all efforts to pay for services rendered in a timely fashion. I am signing this agreement prior to receiving any professional services and understand that should I choose not to proceed with my initial session due to my finding the terms of this agreement unacceptable I will not be charged for the canceled session.

Signature: _____

Print Name _____

Date Signed __ __

Signature: _____

Print Name _____

Date Signed __ __



CHILD CLIENT INFORMATION FORM

Today's Date:			
Presenting Problem:			
Client's Name:		Non-Custodial Parents' Names:	
Date of Birth:	Age:		
School:		Address:	
Grade:		City/State/Zip:	
Custodial Parent's Names:		Non-Custodial Parent's Cell Phones:	
Home Address:		Non-Custodial Parent's E-Mails:	
City/State/Zip:			
Custodial Parent's Cell Phones:	M: F:	Non-Custodial Parent's Education:	M: F:
Custodial Parent's E-Mails:	M: F:	Non-Custodial Parent's Occupations:	M: F:
Custodial Parent's Occupations:	M: F:		
Siblings' Names/Ages:			
Pediatrician's Name:		Phone Number:	
INSURED'S INFORMATION IF USING INSURANCE			
Primary Insurance Company:		Secondary Insurance Company:	
Insured's Name:		Insured's Name:	
Insured's Employer:		Insured's Employer:	
Insured's Date of Birth:		Insured's Date of Birth:	
Address:		Address:	
State/Zip Code:		State/Zip Code:	
Ins. Co. Tel. #:		Ins. Co. Tel. #:	
Employer:		Employer:	
Policy Number:		Policy Number:	
Group Number:		Group Number:	
Effective Date:		Effective Date:	
Deductible:		Deductible:	
	Met:		Met:
Co-Pay:		Co-Pay:	
Precert? Auth. #:		Initial Diagnostic Impression:	



OFFICE POLICIES AND PSYCHOLOGICAL SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. The law requires that I obtain your signature acknowledging that I have provided you with this information at or before the end of the first meeting. Although these documents are long and sometimes complex, it is very important that you read them carefully. I can discuss any questions you have about the procedures during the first meeting. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

I specialize in the assessment, diagnosis and treatment of learning, relationship, psychological, and some neuropsychological disorders. By signing this agreement, you are giving consent for yourself or your child/adolescent to undergo psychological evaluation and/or treatment. As a licensed psychologist, I will be performing this evaluation and/or treatment.

Psychological Testing

A psychological evaluation is a comprehensive assessment of cognitive, educational, and social/emotional functioning. Over a period of 4 to 8 hours, standard testing procedures assess various abilities that relate to cognition, learning, memory, problem solving and critical thinking. The evaluation also measures psychological dimensions relating to social and emotional functioning. The evaluation may also be used to procure public school or college classroom/teaching accommodations for you or your child in order to obtain more effective learning experiences. Also, psychological testing may be used to provide medical clearance, fitness for duty to return to work, or parental competence in a court of law. If you have further questions about the purpose and potential benefits of a psychological evaluation, I will be happy to provide additional information.

Psychotherapy

Psychotherapy, or mental health counseling, is a complex array of many activities that serve to build a trusting relationship between the client and their therapist. This array of activities may consist of play, dance or movement, physical exercise, education, learning, application and practice of that learning, assimilation of learning into behavior and integration of what is learned and practiced into ethical, morally mature, socially responsible and healthy personality functioning. The transformation that occurs through this complex array of activities with the therapist involves easing of personal defense mechanisms that permit insight into one's own emotional life and habitual ways of behaving socially.

Self-control and improved social and moral functioning comes through the development of self-awareness, rational thought, appropriate expression of emotions, planning, anticipation of consequences, mental flexibility, self-acceptance, genuine regard for others' feelings, beliefs, and opinions, and capitalizing on one's existing strengths and resources. By forming a therapeutic alliance with Dr. Kovner the client works to improve their chances of success in achieving the goals of emotional stability, personal and interpersonal growth, occupational and educational satisfaction and social responsibility. Furthermore, research has shown that improvement in mental health can have a beneficial affect on physical health.

CONTACT INFORMATION AND EMERGENCY PROCEDURES

Often I am not available immediately by telephone. I do not answer the phone when I am in a meeting with a client. On days that I are not in the office, I check voice mail frequently. When I am unavailable, the telephone is answered by the office manager or an answering machine. I will try to return your call within one business day of receiving it, with the exception of holidays and vacations.

If you are difficult to reach, please inform us of some times when you will be available. My practice does not have 24 hour crisis availability, support staff, or a psychiatrist. If it is possible you will need crisis services over the course of treatment it is important that you discuss this point with me as soon as possible. I may recommend that you seek services with a provider who can offer more crisis coverage than can be provided by my private practice.

However, in case of an emergency, this is the protocol I follow. In an emergency, you may try to reach me at the office number. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. In a situation where serious harm may occur, call 911 or get safe transportation to the nearest hospital emergency room. If you are able to wait for a return call, clients with life-threatening emergencies will be seen immediately, or directed to emergency care. Clients with non-life threatening emergency needs will be seen within (6) hours or directed to emergency care. Clients with urgent care needs will receive care within 24 hours.

If I will be unavailable for an extended time and you provide me with a written request I will provide you with the name of a colleague to contact.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in a Clinical Record. Except in unusual circumstances where that disclosure would physically or emotionally endanger you and/or others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. In most circumstances, I am allowed to charge a copying fee of \$0.10 per page (and charge for certain other expenses such as postage and envelopes).

Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence so you can discuss the contents. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

You also may add information to your records when I review them with you if you believe they contain inaccurate or incomplete information.

It is my office policy to retain clients' records for seven years after the end of our therapy.

Children and Adolescent Clinical Records

With regards to your child or adolescent, the review of the clinical record would violate the client's confidentiality. Without privacy, most children and adolescents would not talk or disclose matters of true concern and therapy would not be effective. There may be general discussion with you about the goals, progress and effectiveness of therapy at Dr. Kovner's discretion. However, if during the course of treatment, if I were to become concerned that your child's life or safety was endangered your child's confidentiality privileges would be waived. Therefore, before I would agree to treat your child (or adolescent) I request that you consent to waive your right to have a copy of or review the details of the clinical record by signing in the space below.

I, _____, the parent or legal guardian of _____
(Print Parent's or Legal Guardian's Name)

whose date of birth is _____, waive my right to read, review or own a copy of the clinical record.

Please note that in some cases our files may include information from other treatment providers that clients have given me written permission to obtain. If you have given me permission to obtain such records, I cannot provide them to you if you ask to review your files. Instead, I would ask for you to contact the provider who created the records and obtain copies directly from her or him.

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. I am happy to discuss any of these rights with you.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about you or your child's treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or Georgia law. However, in the following situations, no authorization is required: Disclosures required by health insurers or to collect overdue fees; if you are involved in a court proceeding and a judge waives your privilege to confidentiality. Generally, I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them. In the case of suspected child abuse, the privilege is waived because all psychologists are mandated court reporters of child abuse.

Additionally, I would not need authorization to disclose your records under the following circumstances:

1. If a you file a complaint or lawsuit against me, I may disclose relevant information regarding you and your treatment in order to defend myself.
2. I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of a client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.
3. You should be aware that I practice with other mental health professionals and that I occasionally employ administrative staff. In some cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

There are some situations in which we are legally obligated to take actions where your confidentiality privileges are waived. These situations include instances where we believe it is necessary to attempt to protect others from harm. Under such circumstances, I may have to reveal some information about a patient's treatment. These situations are unusual in our practice, and include:

4. If I know or have reasonable cause to suspect that a child under 18 has been or is likely to be abused or neglected or that a disabled person has been abused, neglected or exploited, the law requires that I file a report with the appropriate government agency, usually the Georgia Department of Child Protective Services. Once such a report is filed, I may be required to provide additional information.
5. If I determine that the patient poses a direct threat of imminent harm to the health or safety of any individual, including himself/herself, I may be required to disclose information in order to take protective action(s). These actions may include notifying the potential victim, contacting the police, seeking hospitalization for the patient, or contacting family members or others who can assist in providing protection.
6. If you have filed a worker's compensation claim and I are being compensated for your treatment by your employer or its insurance company as a result of that claim, I must provide, upon appropriate request, legally required reports and other information related to your condition.

INSURANCE & CONFIDENTIALITY

You should be aware that most insurance companies require you to authorize your treating psychologist to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment

plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information data bank. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above unless prohibited by contract. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit our disclosure to what is necessary.

Please indicate below your intention to use health insurance.

I have decided:

) not to utilize my health insurance to cover the cost of this evaluation.

to use my health insurance to cover the cost of these services. My signature on this agreement verifies that I understand that a pre-authorization from my insurance company is not a guarantee that your insurance company will pay for this evaluation. If your insurance company chooses not to pay, or to pay only partially for this service, you have agreed to pay the full amount

My usual and customary fee is \$175.00 per hour. I charge this amount for other professional services you may need. Other services include:

- Psychological Testing
- Report Writing
- Telephone consultations lasting longer than 10 minutes
- Consultations with other professionals
- Preparing records or treatment summaries for court

If you become involved in legal proceedings through the court system or hire me to support your child in an IEP meeting, Board Meeting, or Tribunal Hearing through the school system, you will be charged \$200.00 per hour for travel, wait time, preparation and attendance. I require a \$1,600.00 retainer before work is begun.

If you plan to use your health care insurance, you are expected to contact them and be informed of your Mental Health benefits. We cannot be responsible for interpreting your insurance benefits. Unless your insurance company has contracted directly with the Kovner Center, this office cannot call, contact or negotiate for you with your insurance company. However, we will print out statements for you to submit for reimbursement. Any special arrangements must be discussed in advanced with the office manager. Missed appointments are generally not insurance reimbursable.

It may be helpful to keep your credit card on file to make your payments. If so, please fill out the form below.

CREDIT CARD AND AUTHORIZATION FORM

Credit Card Number		Expirations Date	/	Security Code	
Your Zip Code:		The services rendered are checked below.			
		<input type="checkbox"/> Diagnostic Interview		<input type="checkbox"/> Psychotherapy 50-60 Min.	
		<input type="checkbox"/> Psychological Evaluation		<input type="checkbox"/> Court Testimony	
		<input type="checkbox"/> Two-Day Couples Retreat		<input type="checkbox"/> Written Correspondence	
		<input type="checkbox"/> Test Results Feedback		<input type="checkbox"/> School Board, IEP or Tribunal Hearing	
		<input type="checkbox"/> Phone Consultations greater than 10 minutes			
_____		_____			
Authorizing Signature		Date			

CANCELLATION POLICY AND RESCHEDULING APPOINTMENTS

In order to accommodate you we offer flexible appointment hours, including after-school and evening hours. When you schedule an appointment, that time is yours and you pay for that time whether you use it and attend your appointment or you fail to show up or fail to cancel your appointment at least two days prior. We charge a \$50.00 fee for not canceling your appointment 2 days in advance. We refer to this as the **Cancellation Fee**. The fee may be waived at Dr. Kovner’s discretion when you were unable to attend due to circumstances beyond your control.

Individuals who miss two consecutive appointments without advanced notification will be taken off the calendar. There may be situations when I agree that you were unable to attend due to circumstances beyond your control. Under these circumstances, the fee will be waived at Dr. Kovner’s discretion.

RETURNED CHECK FEES

There will be a \$35.00 charge for each returned check to cover all of the expenses involved in paying bank fees and other resulting insufficient funds charges.

LATE FEES AND NON-PAYMENT ACTIONS

After 30 days 1% of a 12% annual interest charge is added to the standing balance on your account. Interest will accrue monthly. After 90 days of not making payments, a collection action will be taken, including a report to all three credit companies. A Small Claims suit will be filed. Afterwards, Garnishment of your banking assets or those held by your employer will be pursued in Small Claims Court.

EATING OR SMOKING

No Eating or Smoking is permitted in the Building. If you smoke outside, please throw your used cigarette into the plastic receptacle out front. Children are to wait quietly in the waiting room. Parents must accompany young children to the bathroom and make sure all doors are closed and the facilities are left clean. Do not leave children unsupervised in or outside of the office.

THE WAITING AREA

Clients are to wait quietly in the waiting room. Please be courteous and turn your cell phones to vibrate. Please use ear buds to listen to music and voices down to a whisper if you talk on your cell phone. We use the radio to provide the Office Manager privacy. She has limited time. Please respect her time and privacy.

All clinical information is to be presented *in therapy sessions by appointment.*

PARENT'S QUESTIONNAIRE

Today's Date: _____

Child's Name:		Date of Birth:		Age:	
Referred By:					
Presenting problem:					
Family Relationships					
Biological Mother's Name:		Biological Father's Name:			
Education:		Education:			
Occupation:		Occupation:			
Stepfather:		Stepmother:			
Guardian:		Siblings:			
How does child get along with siblings?					
CHILD'S BIRTH AND EARLY DEVELOPMENT					
Was pregnancy planned?					
Premature? If yes, how weeks?					
Adopted?					
Birth Weight					
How was mother's health during pregnancy?					
Any problems at birth?					
Any feeding difficulties?					
Any sleep difficulties?					
Approximate age when child: Sat alone					
Walked alone					
Correctly used one-word speech					
3 word sentences					
Any hearing difficulties?					
Any trouble with eyesight?					

Anything unusual about speech development?			
Is child over or under active?			
Is child excessively aggressive?			
How does child react to new situations and changes in routine?			
Please check any of the problems below that your child has:			
Fingernail biting)	Thumb sucking	Body rocking	Sleep walking
Fire setting	Temper tantrums	Stealing	Truancy)
Accident proneness	Concerns about eating	Concerns about sleep habits)	
Self-injury	Unusual perceptions	Night terrors of nightmares	

EDUCATIONAL HISTORY List in chronological order all

schools your child has attended.

Name of School	Dates Attended		Grade Level	GPA	Conduct
	From	To			
	From	To			
	From	To			
	From	To			
	From	To			
	From	To			
	From	To			

Name of current teachers _____

Child's favorite subjects _____

Child's least favorite subjects _____

Has your child ever repeated a grade? _____ If so, which? _____

Has your child ever skipped a grade? _____ If so, which? _____

Has your child ever received tutoring? _____

Has your child ever been in a Special Education Program? _____ If so, in which subject(s)? _____

_____ If so, during which years? _____

What type of Program? (Gifted, LD, BD/EH, MR?) _____

Child's attitude toward school _____

How well does your child get along with other children? _____

Please describe your child's strengths _____

Describe your child's weaknesses _____

Child's extracurricular activities including sports, hobbies, clubs, lessons, etc.

Baseball _____ Karate _____ Dance _____
Football _____ Piano _____ (type) _____
Basketball _____ Cheerleading _____ Music _____
Soccer _____ Scouts _____ Other: _____

List any additional special abilities, skills, strengths your child has. _____

PSYCHOLOGICAL/PSYCHIATRIC HISTORY

Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was your understanding of their findings? _____

Has your child been hospitalized for a psychiatric condition? If yes, when and where? _____

_____ Is your child taking medication? If yes, what medications are they, what dose, and for what condition?

For what Condition Medication is Prescribed for?	Date Prescribed?	Name of Medication?	Dose?

Are there any family members on either side of the family who have ever been treated for mental or emotional problems? If yes, specify. _____

Parents' Self-Descriptions

How would you rate your overall level of happiness on a scale from 1 (Happy) to 10 (Unhappy).

Mother _____ Father _____

On a scale from 1 (Low) to 10 (High), how would you rate your stress in the following areas ?

Mother's Ratings Father's Ratings

Job		
Home Life		
Parenting		
Friends/Social Life		
Day to day hassles		
Your marriage		
Finances		
Intimacy		
Communication		
Time Together		
Overall Stress		

DISCIPLINE

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies with them on a scale from 1 (Unlikely) to 5 (Likely). Also, please indicate how effective each of the disciplinary strategies is for your child by rating them from 1 (Ineffective) to 5 (Effective). Either circle the number or write the number in the field to the right of the score range.

	Unlikely					Likely					Ineffective					Effective				
1. Let situation go.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
2. Use token system.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
3. Take away a privilege (e.g., T.V.).....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
4. Use charts & stickers.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
5. Earn privileges.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
6. Earn time with friends.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
7. Take away something material (e.g., no dessert).....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
8. Earn special time with parents.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
9. Send to room.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
10. Give verbal praise.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
11. Physical punishment.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
12. Reason with child.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
13. Earns material or food reward.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
14. Teach desired behavior by discussion.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
15. Ground child.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
16. Teach appropriate behavior by modeling.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
17. Yell at child.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
18. Teach desired behavior by role-playing.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
19. Earn participation in social activities.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
20. Send to time-out.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
21. Reward positive behavior.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
22. List anything else you may do: _____	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
23. _____	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
24. _____	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
25. _____	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
26. _____	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5