Shena Silver

**Founder of FRF LLC**

FRIENDSRFAMILY LLC is a brand that recognizes the relationships we have with individuals that are not DNA related, however shares the same value. FRIENDSRFAMILY has its own branding of clothing and products. FRF is a business that customizes apparel and designs. We’ve hosted a variety of community events. Currently, we are upcoming service providers, providing services to individuals of the autism spectrum.

We aim to create services that support the meaning of this brand, to change the lives of individuals by offering services in a safe environment. Leading to creating employment opportunities to support the financial needs of many employees. Therefore, we’ve launched a new non-profit arm “Directions to Discovery Inc”.

*DIRECTIONS TO DISCOVERY is a nonprofit organization that service individuals of the autism spectrum. We are offering services that provide opportunities for individuals to develop self-sufficient skills and practice independent living skills away from home. There are options available to meet the needs of the people we serve. Our goal is to help our clients, and their families reduce stress and gain security and assurance when it comes to their lives, loved ones, and future.*

 *We’re in this Together.*

For more information, please visit our website at [www.friendsrfamily.org](http://www.friendsrfamily.org).

You can contact us via EMAIL at FRIENDSRFAMILY2020@GMAIL.COM or by PHONE (276)-356-9019 to discuss our upcoming services and how you can get involved.

Thank you so much for your time & support, and we hope to see you soon!

Sincerely, Shena Silver, Manager

**Direction to Discovery Autism Package Plans**

Payment Acceptance: Private Pay (Invoice from FRIENDRFAMILY LLC)

 Medicaid: Pending Authorization

1. **Level 1: Package 1**

The **“MEET YOU THERE”** package. This package is the entry level package. We will provide weekday in-home services (in their homes) to individuals on the autism spectrum. This service will prepare each individual and their families to transition into our care, our homes. This process includes observations of the individual, building relationships, taking steps towards transitioning into one of our homes to begin the journey towards becoming self-sufficient. This plan also includes:

Observation & Assessments

Building Rapport/Relationship

Family/Group Therapy

Intensive In-Home Care

Routine Management

Academic Support

Career & Vocational Support

Community Living & Support

Self-sufficient Skill Development

Coping and Advocacy Development

Individual & Transition Support

Mobile Crisis Management

Our goal is to build up courage, trust relationships, and knowledge to graduate to our next level of receiving the next level (level 2) of care.

This plan starts at $250 weekly (1000.00 monthly).

1. **Level 2: PACKAGE 2**

The **“COME OVER”** package provides services as well as personal care services.

Including the services of level one, we will provide individuals with the opportunity to receive intensive therapy outside of their normal environment during the weekdays. This service requires individuals to stay overnight (Monday-Thursdays nights) in our care. This will encourage individuals to generalize the skills learned during level 1, during in-home therapy. This service will also include enrollment/Transportation to day programs or employment opportunities in the community as well as with FRIENDSRFAMILY: creating productions. This will service as follow:

Observations & Assessments

Crisis Management

In Our Home Care Weekdays

Personal Care

Developing Self-Sufficient skills

Routine Development

Academic Support

Social & Peer Support

Career & Vocational Training

Intensive In-Home Care

Assertive Community Support

Individual and Transitional Support

Community Living and Support

This plan starts at $300 weekly ($1,200.00)

1. **Level 3: PACKAGE 3**

The **“AWAY FROM HOME”** package provides individuals with the opportunity to practice independent living with options containing a long term stay in our care. This service’s stay duration is 7 days a week to 3 months, unless failure to comply with our policies we look forward to working with you. After each evaluation, there will be a “progress determination” to determine to continue services, include other services, or options to pause/discontinue services with us. However, this package does include the programs from level 2. This package includes:

Observation, Assessments, & Residential Services

Personal Care

Intensive In-Home Services

Routine Development

Academic Support

Social & Peer Support

Career & Vocational Training

Personnel & Employment Consulting

Individual and Transitional Support

Supporting Living Services

This plan starts at $375 weekly (1,500.00)

***CLIENT POLICIES***

*Revised January 2025*

Welcome to DIRECTIONS TO DISCOVERY, Inc. (DTD). We are pleased to work with our loved ones and family. Our mission is to provide children with the opportunity to attain their highest developmental potential using a collaborative and caring, multi-disciplinary team approach. We strive to provide quality therapy services, which do not separate the child from the context of the family or typical everyday environments and ultimately enable the child to engage in activities that give meaning to his/her/their life. To serve you and your child effectively under a mutual understanding of our guidelines, **please carefully read the following policies and sign them at the bottom of the page. Note that policies are subject to change with two weeks notice.**

***PRIOR TO SERVICES***

1. All forms must be submitted online. A credit card must be left on file to pay for services, applicable deductibles, copayments, and fees.
2. Unless they pay privately, authorizations must be in place prior to receiving services. If using insurance, it is recommended that I check with the insurance company to ensure that the requested services are covered by the relevant policy. DTD will also contact the insurance company once I have provided my information. If the front office indicates that a prescription is required, I must obtain this from my loved one's doctor and provide it to DTD prior to the appointment.
3. Once an evaluation is completed, if treatment is recommended, DTD will attempt to place my loved one on the schedule. However, DTD cannot guarantee immediate availability.

***CONDITIONS OF TREATMENT***

1. CONSENT TO TREATMENT/ASSESSMENT
I hereby consent to the administration and performance of all evaluation procedures and treatments within the realm of current standards of practice, which in the judgement of my loved one’s therapist may be considered necessary or advisable.
2. CONSENT TO TELEHEALTH TREATMENT
DTD may recommend services through telehealth if clinically appropriate. I understand that my person will be receiving care through interactive audio, video, and other telecommunication technologies with a therapist who is not in the same physical location as me and my person. I understand that I am expected to provide a safe environment with minimized distractions for my love one to participate in telehealth treatment. There is a risk that the quality of my child’s telehealth services will be diminished based on the difficulty of communicating and transmitting information without the benefit of being physically present and receiving non-verbal cues, and that there is greater risk of distraction from participants at remote locations. DTD, my child, and I will see and hear each other electronically, but some information the participants would ordinarily get in-person will be unavailable. There is a risk that, in the event of an emergency, my child and I will be alone and without the benefits of in-person interaction to support us through a moment of difficulty. There is a greater risk of intentional or unintentional violation of the confidentiality of client/patient information when transmitted electronically resulting in risks such as interception, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. There is a risk of technology failure and interruption by a connectivity problem. I will need access to, and familiarity with, the appropriate, working technology for my child and me to participate in the services provided by DTD, with a risk of corruption or technology interruptions. I also agree that my child and I are responsible for timely attendance, and that I remain responsible for adhering to DTD’s “Third-Party Funders,” “Parent Presence,” and “Attendance” policies, and the cancellation fees for missed telehealth appointments.
3. CONSENT TO USE OF THERAPEUTIC EQUIPMENT
I, on my behalf and on behalf of my child, fully understand that there is a risk of personal injury to my child in participating in play-based activities and other physically active games through the programs provided by DTD. I am aware that my child is engaging in physically active games and/or therapeutic activities, which could result in injury. I am voluntarily allowing my child to participate in these activities and assume all risks of injury that may result. I personally, and on behalf of my child, agree to hold no individual or corporation responsible or liable for any injuries and associated costs that my child receives on account of these activities, including but not limited to DTD, or it’s officers, employees, agents, aides, therapists, assistants, successors, instructors, insurers, or assigns (hereinafter “Releases”). I further agree to waive any claims or causes of action against and to hold harmless said Releases for any injuries or damages which my child suffers or might suffer as a result of the conduct of any person during or in conjunction with said physically active games or therapeutic play-based activities.
4. CONSENT TO PHOTOGRAPHY
I hereby agree to allow DTD to take and/or use any pictures/tapes/videos/films of me or my child with my full knowledge and consent as a client of DTD. This visual record may be used for teaching and training activities and/or as a part of my child’s medical/developmental record as DTD may deem proper. My child’s identity will not be made public without my expressed permission for a specific occasion or purpose. Any use of my child for public relations will also require my specific permission and knowledge.
5. CONSENT FOR EMERGENCY TREATMENT
As the authorized representative, I hereby give consent for DTS, to obtain all emergency medical or dental care prescribed by a duly licensed physician (M.D), osteopath (D.O.), or dentist (D.D.S.) for my child. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my child. My signature at the bottom of this form testifies that I am the authorized representative of the child named on this document. Further, I will be responsible for the charges for any medical or dental treatment or hospitalization rendered by reason of this authorization.
6. ILLNESS
I understand that in order to attend in person services, households must follow current Pasadena Public Health quarantine/isolation guidelines in case of a COVID-19 exposure or diagnosis (suspected or confirmed). I understand that if a child (or someone in the child’s home) experiences any symptoms of illness, the child should participate in telehealth until all symptoms (including, but not limited to, fever, vomiting, diarrhea, nasal congestion, cough, sore throat, skin irritation) have been fully resolved for at least 24 hours without medication. In the event that mild symptoms persist for more than 5 days, children may be allowed to return in person after presenting a doctor’s note indicating they are not contagious and/or a negative COVID-19 test. I understand that if a child shows symptoms of illness while receiving in person services, DTD staff will separate them from peers and contact caregivers for immediate pick up.
7. SOCIAL CONDUCT
I understand that DTD strives to uphold an environment that is anti-racist, values LGBTQIA+ community members, and affirms neurodivergence. We welcome feedback on how to do this better. I hereby agree to conduct myself in a manner that is in accordance with these goals.
8. RELEASE OF INFORMATION
I hereby agree that DTD may release information, either written or verbal, regarding my child’s medical status and progress to professionals who have been or are currently involved in the treatment of my child. I hereby agree that, to the extent necessary to determine eligibility for services and to obtain reimbursement, DTD may disclose portions of my child’s records to funding agencies such as health care insurance plans, school districts, and regional centers.
9. ATTENDANCE AND CANCELLATIONS
It is extremely important to consistently attend appointments on time and avoid cancellations. At least 75% of sessions must be attended on time in order to maintain a standing appointment time. Frequent late arrivals or missing 25% or more appointments in a 3 month period may result in my child's therapy schedule being terminated. If a therapy session must be missed, all cancellations must be sent to friendsrfamily2020@gmail.com.

I understand that there are fees for late cancellations of clinic sessions, those cancelled less than 24 hours prior to the appointment time for any reason including illness. These fees start with the 4th occurrence ($50) and increase with the 7th occurrence ($75). There are fees for “no shows,” sessions that are not attended and not cancelled in advance of the session start time. The no show fee is billed at the current private pay session rate ($50). If my child arrives late to a session, I understand that it is my responsibility to contact DTD by phone or email within the first 15 minutes of the session, or the session is automatically cancelled and billed as a no show. Late cancellation and no show fees are subject to change at any time.

1. VACATIONS AND EXTENDED ABSENCES
If five consecutive treatment sessions are cancelled or missed, for example due to vacations or serious illness, that appointment time may not be reserved.
2. FINANCIAL AGREEMENT
I hereby agree to allow DTD to charge my credit card on file for services rendered. Invoices with service details will be available promptly after payments are confirmed. I agree to pay interest at the legal rate should the account become delinquent, and if it becomes necessary for the account to be referred to as an attorney for collection, I shall pay the actual attorney’s fees and collection expenses.
3. THIRD-PARTY FUNDERS
An explanation of charges will accompany my payment receipt and invoice. It is my responsibility to notify the front office at DTD if there are changes to my child’s insurance. In the event that my insurance or other funding agency does not pay within 90 days for rendered services, regardless of the reason, I am responsible for payment. I understand that school districts fund therapy services only on days when school is in session and my child attends school. School districts do not fund during school calendar vacations or holidays unless otherwise indicated in writing. Occasionally, with written permission from the district, schools may fund a session when my child’s school is out. I understand that it is my responsibility to obtain and monitor my child’s school calendar and pay privately for sessions that are not covered by the school district.
4. SIBLINGS AND ACCOMPANYING CHILDREN
I understand that caregivers are responsible for supervising registered participants brought to the DTD, and that only children under direct care of a DTD therapist may use equipment and toys in the treatment space.
5. END OF SESSIONS
I understand that discussions with caregivers about activities and goal progress are part of intervention. Therapists and children may arrive in the waiting room prior to the session ending to account for this.
6. EMERGENCY CONTACTS
I understand that DTD may contact or release my child to emergency contacts I list on this form if a primary guardian is not available at the end of a session or program, or in the case of an emergency.
7. EMERGENCY EVENT
Following an emergency event, assuming conditions are deemed safe, children will be released to their guardians. If it is not feasible for a guardian to pick up a child, employees will take children to a verified safe location determined by the American Red Cross and/or communicated by the National Emergency Broadcast System. In an immediate building evacuation, employees and children will be instructed to assemble at the nearby Lamanda Park Branch Library.
8. RE-EVALUATIONS
3 Months evaluations are conducted for client per standard best practice guidelines. Evaluations of services through a funding agency are conducted according to the agency’s guidelines.
9. NON-DISCRIMINATION
DTD strives to maintain an inclusive environment without discriminating on the basis of race, religion, sex, national origin, sexual orientation, age, or disability. I understand that I and other guardians of my child are expected to participate in this endeavor and show mutual respect for members of our community.

***HIPAA. NOTICE OF PRIVACY PRACTICES***

This section describes how medical information about your child may be used and disclosed, and how you can get access to this information. Please review it carefully.

***USES AND DISCLOSURES\****

1. We will use your child’s protected health information (PHI) for the purposes of treatment, payment and health care operations.
2. Treatment includes the disclosure of health information to other providers who have referred your child for services or are involved in his/her care. This may include doctors, nurses, other occupational therapists, physical therapists, or speech therapists, psychologists, regional center service coordinators, or schools.
3. Payment includes the disclosure of health information to your insurance company or to a school district or regional center so payment can be obtained for services rendered.
4. Health Care operations include the utilization of your child’s records to monitor the quality of care being provided at our facility.
5. Our practice may use your child’s PHI to request information about your child or to send you information regarding other health or therapy-related services.
6. The federal health information policy regulations either permit or require us to use or disclose your child’s PHI in the following ways: we may share some of your child’s PHI with a family member or friend involved in your child’s care if you do not object, or we may use your child’s PHI in an emergency situation when you may not be able to express your wishes for your child. We may also disclose your child’s PHI when we are required to do so by law, for example, by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about your child to avert a serious threat to your child’s health or safety, or to the health or safety of the public or others. Your authorization is required before your child’s PHI may be used or disclosed by us for any other purposes.

\* Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permissions.

***PRIVACY RIGHTS\*\****

1. RESTRICTIONS
You have the right to request restrictions on how your child’s PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.
2. CONFIDENTIAL COMMUNICATIONS
You have the right to request in writing the way we communicate with you about medical matters in a certain way or at a certain location.
3. ACCESS TO PHI
You have the right to request a copy of your child’s medical record. This request must be in writing and we may charge a fee to cover the copying and mailing.
4. AMENDMENTS
If you feel that medical information we have about you or your child is incomplete or inaccurate, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request.
5. RESTRICTIONS
You have the right to request a restriction or limitation on the medical information we use or disclose about your child for treatment, payment, or health care operations.
6. ACCOUNTING OF DISCLOSURES
You have the right to request in writing, a list of accounting for any disclosures of your child’s medical information we have made, except for uses and disclosures of treatment, payment, and health care operations, as previously described.
7. PAPER COPY
You have the right to a paper copy of this notice at any time.

\*\* If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

I have reviewed, understand, and agree to the above policies and Notice of Privacy Practices.