EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Intake Checklist

Child's Name: _____ Parent/Legal Guardian Name: _____

Below is a list of items that must be completed as part of our Client Intake Packet. For your convenience, there is a checkbox for each required and optional document.

Required Forms:

- Client History Form
- Discipline-Specific Intake Forms
  - ABA (Behavior Intervention)
  - Occupational Therapy
  - Physical Therapy
  - Speech Therapy
  - Psychology
- Informed Consent
- Custodial/Court Documentation Acknowledgement
- Release/Obtain Information Form
- Health Policy
  - Allergy Plan (if applicable)
  - Seizure Plan (if applicable)
  - Asthma Plan (if applicable)
- Cancellation/Tardiness, Illness and HIPAA Policies
- Financial Policy
- Copy of Insurance Card (front and back)

Optional Forms:

- Prior Evaluations
- IEP or 504 Documents
- Prescription for Services

I have completed, signed and attached all required items and the optional items checked off above.

_____ _____

Parent's Signature Date

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Client History Form

General Information

Child's Full Name: _____ DOB: _____

Parent or Caretaker's Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Is this address the same as your billing address? ☐ Yes ☐ No

If no please provide both your billing address: _____

_____

Who lives in the home with you? _____

Relationship to Patient: _____ Primary Phone: _____ Alternate Phone: _____

Email: _____

Full Custody_____ Other_____ if other, please provide a copy of the custody agreement

***if partial or joint custody, both parties will need to consent to treatment**

Alternate Email and Relationship to Patient:

_____

Language(s) spoken at home: _____

How did you hear about EBS Children's Institute? _____

Emergency Contact Information

Emergency Contact Name 1: _____

Relationship to Patient: _____ Phone: _____

Emergency Contact Name 2: _____

Relationship to Patient: _____ Phone: _____

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Client History Form

Present Medical Information

Describe present concern related to appointment:

_____

_____

_____

Have any previous therapies or approaches been attempted? ☐ Yes ☐ No

If yes please describe: _____

Has there been any significant medical or behavioral changes in the past 6 months? ☐ Yes ☐ No

If yes, what has changed? _____

Please list any allergies: _____

What is your child's current health? ☐ Good ☐ Fair ☐ Poor

Is your child taking any medications? ☐ Yes ☐ No If yes what? _____

Does your child have any other medical diagnosis or concerns? _____

Does your child have any adaptive or medical equipment? _____

Indicate any illnesses, accidents, hospitalizations (include age/treatment): _____

_____

Does your child have problems hearing? ☐ Yes ☐ No

If yes, please explain: _____

Has your child experienced any ear infections? ☐ Yes ☐ No

Approximately how often? Rarely Occasionally Often

Has your child had middle ear tubes inserted? ☐ Yes ☐ No

If yes, when? _____

Client History Form

Has your child's hearing ever been tested? ☐ Yes ☐ No

Results: _____

Did your child have his/her adenoids or tonsils removed? ☐ Yes ☐ No

If yes, when? _____

Does your child snore? ☐ Yes ☐ No

Does your child wear corrective lenses (glasses, contacts)? ☐ Yes ☐ No

If yes, at what age did your child begin to wear them? _____

Therapy Goals

Please describe your goals for therapy. What do you hope to accomplish? _____

_____

Are you in need of any additional supports besides what you are being seen for today? ☐ Yes ☐ No

If yes, please describe: _____

Birth History

Was pregnancy full term? ☐ Yes ☐ No

At how many gestational weeks was child born?

Was there anything remarkable about the mother's health during pregnancy or delivery? ☐ Yes ☐ No

If yes, please explain: _____

Type of Delivery: ☐ Vaginal ☐ Caesarian ☐ Breech ☐ Suction ☐ Forceps

Was there any type of diagnosis or medical concern about the baby after birth? ☐ Yes ☐ No

If yes, please explain: _____

Please describe any family history of developmental or learning problems:

_____

_____

Client History Form

Education/Therapy Information

Is your child enrolled in any type of childcare facility, preschool program, play group, developmental program, public school or private school? ☐ Yes ☐ No

Name of School/Facility: _____ How long have they attended? _____

Hours enrolled per week: _____ Current Grade Level: _____

Has your child ever had a school-based evaluation? ☐ Yes ☐ No

Please briefly describe the results: _____

_____

Does your child have an IEP? ☐ Yes ☐ No

What type of services do they receive? _____

Please provide a copy of the IEP and Evaluation to EBS Children's Institute.

Does your child receive speech/occupational/physical/counseling therapy at this time? ☐ Yes ☐ No

Speech Therapy	_____x/week
Language Therapy	x/week
Occupational Therapy	_____x/week
Physical Therapy	_____x/week
Counseling	_____x/week

Where are these services provided? _____

Informed Consent

Child's Name: _____

CONSENT FOR THERAPEUTIC TREATMENT
I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at EBS Children's Institute. I understand that I may terminate these services at any time**.**

_____ _____
Signature of Parent or Legal Guardian Date

***IF SHARED CUSTODY: both parties must sign this consent prior to treatment.**

I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at EBS Children's Institute. I understand that I may terminate these services at any time**.**

_____ _____
Signature of Parent or Legal Guardian Date

CONSENT FOR PARTICIPATION WITH THERAPEUTIC EQUIPMENT
Intervention programs at EBS Children's Institute usually involve the use of specialized equipment such as various swings, bolsters, inflated therapy balls, climbing structures, tactile media (such as soap foam, Play-Doh and lotion), and a variety of other activities that involve fine, gross and oral motor coordination. Therapy activities often involve encouraging the child to try new equipment in order to foster
increased skills and abilities. While our staff make great efforts to ensure each child's safety, the nature of the therapeutic intervention includes the risk of falling, bumping into other people/equipment. I am aware of the inherent risk of this type of activity, and I give permission for my child to participate in therapy as described.

_____ _____
Signature of Parent or Legal Guardian Date

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Informed Consent

REVIEW OF RECORDS/RELEASE OF INFORMATION

I consent to communication between EBS Children's Institute and other therapists, teachers, and/or doctors that have previously worked and/or are currently working with my child. I understand that information may be shared with another member of my child's treatment team outside of EBS, as well as shared with professionals within EBS as part of the treatment process.

I understand that the information that is released between the treatment providers is confidential and is for the well -being of my child.

_____ _____

Signature of Parent or Legal Guardian Date

CONSENT FOR VIDEOTAPING AND PHOTOGRAPHING FOR THERAPEUTIC PURPOSES

Therapists often videotape or photograph children who receive therapy services at EBS to help monitor and document a child's areas of concern, as well as progress. Videotapes and photos are used and reviewed only by EBS staff. Parents are welcome to view their child's videotape at EBS.

I do_____do not_____give consent for my child to be videotaped and/or photographed as part of his/her therapy program for use by EBS Children's Institute staff only.

_____ _____

Signature of Parent or Legal Guardian Date

CONSENT FOR VIDEOTAPING AND PHOTOGRAPHING FOR EDUCATIONAL AND PUBLIC AWARENESS PURPOSES

Staff at EBS are frequently asked to teach at courses, seminars or workshops. We often like to include videotape, slides or photos during our presentations. Additionally, we may occasionally use photographs to share on Social Media and for promotional purposes.

I do___do not___give permission for my child to be videotaped/photographed for educational and public relations purposes. I understand that my child's name and any identifying information, will not be used in association with these images.

_____ _____

Signature of Parent or Legal Guardian Date

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Information about Graduate Interns and Observers

EBS Children's Institute is dedicated to providing quality therapy services to our clients. As part of our mission, we also partner with local universities to provide quality training and mentoring to student clinicians who are completing their studies in the fields of Speech-Language Pathology, Occupational Therapy, Physical Therapy, Behavior Therapy, and Psychology. Therefore, your child may be seen for treatment by the regularly assigned therapist along with a graduate intern. Please be assured that the intern is receiving one-one mentoring from your child's therapist and that the intern is a Master's level graduate student who has been carefully selected to train at EBS Children's Institute. In addition, from time to time, we receive requests from the local universities to allow for undergraduate student clinicians to observe therapy sessions. These students are required to obtain a certain number of hours of observation before they can start a formal internship program. If you have any questions regarding our internship or observation programs, please see our Clinic Director so that your concerns can be addressed. We thank you in advance.

By signing this form, I understand and consent to the possibility that there may be a graduate intern assigned to my child's therapy program and have the right to deny this consent at any time by alerting the Clinic Director.

Child's Name (Print): _____

Parent/Legal Guardian Name (Print):

_____

Parent/Legal Guardian Signature:

_____

Date: _____

EBSCI
CHILDREN'S INSTITUTE
Research • Training • Treatment

Custodial Court/Documentation Acknowledgement

I, the parent/guardian, _____, do hereby acknowledge that there is **NO** custodial/court

Documentation in place for the child(ren) listed below as of today's date, _____

Child(ren)'s name(s):

_____

Parent/Legal Guardian Signature: _____Date: _____

OR if the above is not true, complete the bottom portion of this form:

I, the parent/guardian, _____, do hereby acknowledge that there **is** custodial/court

Documentation in place for the child(ren) listed below as of today's date, _____In addition, I have

Attached the custodial/court documentation to this acknowledgement form.

Child(ren)'s name(s): _____

Parent/Legal Guardian Signature: _____Date: _____

Parent/Legal Guardian Signature: _____Date: _____

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Consent to Release/Obtain Information

I, the parent/guardian, _____, do hereby authorize EBS Children's Institute to RELEASE TO and OBTAIN INFORMATION FROM the record of the individual identified below for therapeutic purposes including collaboration, planning and treatment:

_____	_____
Name of Individual	Name of Agency
_____	_____
Phone Number	Email Address/Fax Number
_____	_____
Name of Individual	Name of Agency
_____	_____
Phone Number	Email Address/Fax Number

_____ _____

Parent/Legal Guardian Signature Date

_____

Relationship to Child/Client

Health Policy

For the safety of your child, parents/guardians of children with Allergies, Asthma, or Seizures you must remain present either in the therapy room or the waiting area during the entire therapy session. If a seizure, asthma attack or allergic reaction occurs during a therapy session, the therapist will need to end the session.

Allergy

Allergy: ☐ Yes ☐ No

Allergic To: _____

Please describe reaction: _____

Medications given: _____

If you checked **yes,** please see the front desk to discuss an allergy plan. If you do **not** feel a plan is necessary at this time, please sign the statement below.

I do **not** feel my child needs an allergy plan at this time.

Signature: _____ Date: _____

Seizure

Seizures: ☐ Yes ☐ No

Frequency: _____

Please describe: _____

Medications given: _____

If you checked **yes,** please see the front desk to discuss a seizure plan. If you do **not** feel a plan is necessary at this time, please sign the statement below.

I do **not** feel my child needs a seizure plan at this time.

Signature: _____ Date: _____

Health Policy

Asthma

Asthma: ☐ Yes ☐ No

Known Triggers: _____

Frequency: _____

Medications given: _____

If you checked **yes,** please see the front desk to discuss an asthma plan. If you do **not** feel a plan is necessary at this time, please sign the statement below.

I do **not** feel my child needs an asthma plan at this time.

Signature: _____ Date: _____

EBS Children's Institute will do its part to work with families of children with medical needs to ensure safety during our therapy sessions. By signing below you agree that you have disclosed any known history of allergies, asthma, or seizures and will work with our staff to create a plan to address these concerns as needed.

Parent Signature: _____ Date: _____

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Allergy Plan

Allergen	Reaction

Date of Plan: _____

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Therapist/Staff Name: _____

Telephone:

Home _____

Cellular _____

Other _____

Physician Name: _____ Telephone: _____

Emergency Contact: _____

Emergency Contact Telephone:

Home _____

Cell _____

Other _____

Brief description of student's allergies and reactions:

_____

_____

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Allergy Plan

If Child Displays the following Symptoms:	Take the following actions:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

EBS Children's Institute staff will do its part to be continually aware of child's specific allergy. However, it is not possible to prevent 100% of all accidental exposures in a center which is frequented by a large group of clients and families each week. By signing below you understand that EBS Children's Institute will not be held liable for any reactions that a child has when in contact with our clinic environment.

Before serving your child, EBS will need a copy of your child's emergency allergy plan. If the emergency plan requires medication (EpiPen, inhaler, etc.) we require parents to stay on the premises for the duration of the session.

Signature: _____

Relationship to Patient: _____ Date: _____

Clinician Signature: _____ Date: _____

Clinical Director Signature: _____ Date: _____

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Seizure Plan

Known Triggers for Seizures:

_____

_____

_____

_____

Date of Plan: _____

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Therapist/Staff Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Physician Name: _____ Telephone: _____

Emergency Contact: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Brief description of child's seizures: _____

_____

If Child Displays the following Symptoms:	Take the following actions:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Seizure Plan

EBS Children's Institute staff will do its part to be continually aware of child's seizure history, avoid known seizure triggers, and monitor at all times for signs and symptoms. As it is not our policy to administer medications, a parent or caregiver must remain present either in the therapy room or the waiting area during the entire therapy session in case such an event may occur. In the event of a seizure EBS Children's Institute staff will work with the family to safely position the child until he or she is stabilized or emergency medical service arrives. The therapy session will end if a seizure occurs. By signing below you understand that EBS Children's Institute will not be held liable for any seizure that a child may have in our clinic environment.

Signature	Relationship to Patient	Date

Clinician Signature	Date

Clinical Director Signature	Date

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Asthma Plan

Known Triggers for Asthma:

_____

_____

_____

Date of Plan: _____

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Therapist/Staff Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Physician Name: _____ Telephone: _____

Emergency Contact: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Brief description of child's asthma and reactions:

_____

_____

_____

If Child Displays the following Symptoms:	Take the following actions:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Asthma Plan

EBS Children's Institute staff will do its part to be continually aware of child's asthma history, avoid known triggers and monitor at all times for signs and symptoms. As it not our policy to administer medications, a parent or caregiver must remain present either in the therapy room or the waiting area during the entire therapy session in case such an event may occur. In the event of an asthma attack, EBS Children's Institute staff will work with the family to safely maintain the child which time the child is okay or emergency medical service arrives. The therapy session will end if an asthma attack occurs. By signing below you understand that EBS Children's Institute will not be held liable for any asthma attacks that a child may have in our clinic environment.

_____ _____

Signature Relationship to Patient

_____

Date

_____ _____

Clinician Signature Clinical Director Signature Patient

_____ _____

Date Date

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Financial Policy

As a courtesy to all of our patients, we will call to verify benefits and will make reasonable effort to collect from your insurance company, should you choose to utilize insurance. Please understand, however, primary responsibility for understanding coverage limits belongs to the parent. There are instances when insurance may deny benefits (deductible not met, services not covered under the plan, etc.) and you will then be responsible for payment. In the event that insurance denies payment, the family may wish to appeal the matter to their insurance company, and we will support the parent in their effort. Any payment which is deemed to be due from the parent (private pay/co-pays) is due at the time of the service.

If a payment plan is required, those terms will be provided to you in writing and agreed upon by both EBS Children's Institute and the person responsible for patient's bills. Please inquire with our office administration regarding rates for services.

Notification of Insurance Changes/Renewal Policy

EBS Children's Institute must have **current** information on file regarding Insurance at **all** times. It is the responsibility of the parent/guardian to know of any and all changes that may occur in your insurance policy. It is also the responsibility of the parent/guardian to be sure that EBS Children's Institute is aware of any and all changes to the policy at or before the time that they go into effect.

Please Note: that many insurance policies change on January each year, however they can change at any time.

***Notification of Change: All changes must be directed to the Clinic Administration Staff and appropriate insurance card and identification provided**

ALL PAYMENTS AND OUTSTANDING BALANCES ARE DUE AT THE TIME OF SERVICE

We thank you in advance for your cooperation and invite you to call the Clinical Director with any questions that you may have about billing.

I have read and agree to my financial responsibility for the services provided to me by EBS Children's Institute. This also certifies that the information I have provided to EBS Children's Institute, to the best of my knowledge, is true and accurate. I authorize my insurance carrier to pay EBS Children's Institute the full and entire amount of the bill incurred by my child.

_____
Child's Name

_____ _____
Signature of Parent or Guardian Date

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Cancellation and Tardiness Policy

Consistency is vital to a successful outcome in the therapy process. In the event that your child is unable to attend sessions regularly, we will work with you and make every effort to accommodate your family's needs by seeking to develop a solution that is in the best interest of your child. **If your child's attendance continues to be inconsistent and is no longer therapeutically appropriate, therapy may be placed on hold until consistency can be improved. Please review the guidelines below regarding the cancellation and tardiness procedures:**

Cancellation Policy: Your child's therapist has reserved valuable time for your child's treatment. Your therapist has prepared for the session and blocked out all other activity during this time. In the event that a therapy session is missed with less than 24 hour notice, a fee of $35 will be assessed to the family. If there are more than three absences without proper notice, in a period of six months, your appointments will be at risk for permanent suspension.

Tardiness: Please call the clinic to notify us when you will be running late for your appointment. If you are more than 15 minutes late, there will be a $25 late fee assessed to the family. If there are more than three instances of tardiness (15 minutes or more) in a period of six months, your appointments will be at risk for permanent suspension.

Illness: Please call the clinic as soon as you know that your child may miss your scheduled session. Refer to the illness policy for additional information.

Vacation: Please inform the clinic at least two weeks prior to absence due to vacation.

Other: Routine Dr.'s visits, meetings and other flexible appointments should be scheduled so they do *not conflict* with *the existing therapy appointment.* Therapy is an important part of your child's schedule, and should be treated as such.

Late fees and late cancellation fees must be paid prior the child's next session at the clinic.

We understand that there are unavoidable instances that require cancellation of the session (illness, family vacation out of town, death in the family, etc.) and we are willing to work with families during these occasional circumstances. Chronic illness will be taken into consideration for continuation of therapy.

Illness Policy

Please understand that, while attendance is vital, it is also important to protect your child, as well as the health of the therapist and other children. We require children to be symptom and fever-free for at least 24 hours prior to returning for a session. If a child is on an antibiotic for an illness, the medication must be administered for at least 24 hours before returning to the clinic. Please call the clinic as soon as you know that your child may miss your scheduled session due to illness.

The following circumstances warrant cancellation (with possible rescheduling) of the therapy session:

- The child is unusually lethargic or irritable
- Presence of yellow or green mucus secretion
- Vomiting/diarrhea
- Fever (within 24 hours of session)
- Seizures
- Open skin sores
- Head lice or nits present
- The child is in a contiguous state of a communicable disease including by not limited to:
    - Pink Eye
    - Explained rash
    - Strep Throat
    - Chickenpox
    - Ringworm - must be 24-48 hours on treatment and completely covered if rash is still present.

HIPAA Notification Policy

Please review our Notice of Privacy Practices carefully.
The privacy of your health information is important to us. This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (09/01/2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice please contact the Clinic Director or front office.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities. If we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as e-mail and voicemail messages, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.35 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (email), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

I have *received a copy* and agree to abide by the terms of EBS Children's Institute:

- **Cancellation/Tardiness Policy**
- **Illness Policy**
- **HIPAA Notification Policy**

I acknowledge that I have received the Notice of Privacy Practices (Notice). The Notice describes, in accordance with the HIPAA Privacy Regulations, how EBS Children's Institute may use and disclose my child's protected health information to carry out treatment, payment or health care operations and for the other specific purposes that are permitted or required by law. The Notice also describes my rights and EBS Children's Institute duties with respect to protected health information about my child.

_____

Child's Name

_____ _____

Signature of Parent or Legal Guardian Date

Notice of Privacy Practices

Section A: To the Patient – *Please read the following statements carefully*.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations (TPO).

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

With my permission the office of ***EBS CHILDREN'S INSTITUTE*** may call my home or other designated location and leave messages on voicemail that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my permission the office of ***EBS CHILDREN'S INSTITUTE*** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient invoices and statements.

With my permission, the office of ***EBS CHILDREN'S INSTITUTE*** may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder and patient invoices and statements.

I have the right to request that ***EBS CHILDREN'S INSTITUTE*** restrict how it uses or discloses my protected health information to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us.

Section B: Parent or Guardian Giving Consent (if Patient is not 18 years of age and their own guardian)

Name: _____ Date: _____

Relationship to Patient: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving written notice of your revocation submitted to ***EBS CHILDREN'S INSTITUTE attn.: Clinic Director***. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may *decline* to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Child's Name: _____

Signature: _____

Date: _____

Authorization for Recurring Credit Card Charges

EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

For your convenience, you may authorize recurring charges to your credit card to pay for your therapy sessions. You will be charged the day of your therapy appointment unless other arrangements have been made. The charge will be made under the name EBS Children's Institute. You agree that no prior notification is necessary unless the amount billed each time exceeds the agreed upon amount below, in which case you will receive notification in advance.

Name of Client: _____

Account Type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Cardholder Name: _____

Credit Card Number: _____

Expiration Date: _____ CVV: _____

I authorize EBS Children's Institute to charge this credit card for professional services and associated charges as agreed below. These charges may include:

Co-pay and/or co-insurance for session: $_____

Self-pay for session or payment for session not covered due to deductible: $_____

Charge for cancellation without 24 hours' notice: $$35.00

Other charges (specify): _____ $_____

I understand that this authorization will remain in effect until I cancel in writing, and I agree to notify EBS Children's Institute in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next bill date.

_____ _____

Signature of Authorized Credit Card User Date