Kids Unlimited SM
THERAPY SERVICES, LLC

Client Intake Form

Client Information Today's Date: _____

Child's Name: _____ Preferred Pronoun:_____ Date of Birth:_____

Current Concerns:

_____

_____

_____

What are your child's strengths? _____

_____

Child's likes: _____

_____

Child's dislikes/fears: _____

_____

Parent/Guardian (1): _____ Preferred Pronoun:_____

Address: _____

Email: _____ Cell Ph: _____

Work Ph: _____ Home Ph: _____

Relation: _____ Occupation: _____

Parent/Guardian (2): _____ Preferred Pronoun:_____

Address: _____

Email: _____ Cell Ph: _____

Work Ph: _____ Home Ph: _____

Relation: _____ Occupation: _____

Other children in the family:

Name:	Age:	Developmental Concerns/Previous Therapies:

With whom does the child spend the most of their time**?** _____

Kids Unlimited SM
THERAPY SERVICES, LLC

Birth/Medical History

Please describe the mother's general health during pregnancy (illness, incidents, medications, etc.):

_____

_____

Labor: ☐ Normal ☐ Induced Apgars _____

Other Conditions: ☐ Cesarean ☐ Premature ☐ Cord Around Neck

☐ Child Rotated ☐ Breech ☐ Twins

Length of Pregnancy: _____ Length of Labor: _____

Child's general condition at birth/infancy: ☐ Colic ☐ Feeding Difficulties

☐ Jaundice ☐ Seizures ☐ Cyanosis (blue baby) ☐ Other: _____

Birth Weight: _____ Birth Hospital: _____

NICU/PICU stay? Please describe length of time/complications:

_____

_____

Family History of Problems/Diseases/Delays:

_____

_____

If child was adopted, please give as much information as possible about the child's biological parents/family history:

_____

_____

Hearing

Newborn Hearing Screen: ☐ PASS ☐ FAIL

Please describe the results of any follow up new born hearing screenings performed:

_____

Has your child received a recent hearing evaluation? When was it? What were the results?

_____

Does your child have a history of ear infections? ☐ Yes ☐ No

If *YES*, approximately how many ear infections have occurred? _____

Does your child have Pressure Equalization (PE) Tubes? ☐ Yes ☐ No

If *YES*, please specify which ear(s) PE tubes were placed? ☐ Left ☐ Right ☐ Bilateral

When and where were the PE tubes placed? _____

Kids Unlimited SM
THERAPY SERVICES, LLC

Current Health (attach additional information, as needed)

Please describe your child's health over the past year:

_____

_____

Please describe any illnesses, hospitalizations, surgeries, and other medical issues your child has experienced (include when they occurred):

_____

_____

Does your child have a medical diagnosis? ☐ No ☐ Yes

If *YES,* which diagnosis was given? _____

When was the diagnosis given? _____

Who gave the diagnosis? _____

Food Allergies: ☐ No ☐ Yes _____

Dietary Restrictions: ☐ No ☐ Yes _____

Other Allergies: ☐ No ☐ Yes _____

Vision Impairment: ☐ No ☐ Yes _____

Glasses: ☐ No ☐ Yes _____

Hearing Impairment: ☐ No ☐ Yes _____

Tonsils/Adenoids Removed: ☐ No ☐ Yes If yes, when? _____

Bowel/Bladder Difficulties: ☐ No ☐ Yes _____

What, if any, therapies has your child previously or currently participated in?

	Start Date	Stop Date	Currently Receiving	Location
Developmental Therapy				
Occupational Therapy				
Physical Therapy				
Speech Therapy				
Social Work / Psychology				
ABA				

Kids Unlimited SM
THERAPY SERVICES, LLC

Does your child see any of the following medical professionals on an ongoing basis:

☐ Allergist ☐ Audiologist ☐ Reading Specialist ☐ Executive Function Coach

☐ Neurologist ☐ GI Doctor ☐ Chiropractor ☐ Ophthalmologist

☐ Other: _____

Does your child use any special equipment (wheelchair, braces, etc.)? ☐ No ☐ Yes

_____

Current Medications (attach list, if necessary)

Medication:	Dosage:	Reason:

Developmental Milestones:

Write the approximate age when your child began to do the following *Physical Milestones:*

Roll Over:		Sit:		Crawl:	
Stand:		Walk:		Run:	
Jump:		Kick a ball:			

Does your child have any gross motor difficulty (walking, running, throwing, catching?)

☐ No ☐ Yes Please describe: _____

Does your child have any fine motor difficulty (holding/manipulating objects, writing, using both hands?)

☐ No ☐ Yes Please describe: _____

Self-Help Skills

Please rate approximately how much assistance your child needs for the following self-help tasks:

	Independent 0% assist	**Minimal** Up to 25% assist	**Moderate** No more than 50% assist	**Maximum** 75% assist	**Dependent** 100% assist
Dressing self	☐	☐	☐	☐	☐
Using Spoon/Fork	☐	☐	☐	☐	☐
Drinking from a Cup	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐

	Independent 0% assist	**Minimal** Up to 25% assist	**Moderate** No more than 50% assist	**Maximum** 75% assist	**Dependent** 100% assist
Washing Hands	☐	☐	☐	☐	☐
Brushing Teeth	☐	☐	☐	☐	☐
Brushing Hair	☐	☐	☐	☐	☐
Fasteners (buttons, zippers, etc.)	☐	☐	☐	☐	☐
Tie Shoes	☐	☐	☐	☐	☐

Communication

Write the approximate age when your child began to do the following *Communication Milestones:*

Babble:		Imitate Words:		Name Simple Objects:	
Use 2-word phrases:		Ask questions:		Engage in conversation:	
Point to pictures:					

Does your child have any communication difficulties? ☐ No ☐ Yes Please describe:

_____

_____

Primary language spoken in the home: _____

Is there another language the child is exposed to? ☐ No ☐ Yes

If *YES,* please list all languages child is exposed: _____

What percentage does your child hear the language? English: _____% Other: _____ %

Does your child understand the language? ☐ No ☐ Yes

Does your child speak the language? ☐ No ☐ Yes

Your child currently communicates using: (check all that apply)

☐ Body Language	☐ Sounds (vowels, grunts)	☐ Gestures
☐ Single Words	☐ Sentences with 2-4 words	☐ Sentences with 4+ words
☐ AAC Device	☐ PECS/Visuals	☐ Sign Language

Kids Unlimited SM
THERAPY SERVICES, LLC

Behavior

Please indicate any safety concerns your child may have:

☐ Self-abusive ☐ Abusive towards other ☐ Eloping ☐ Other:_____

Describe your child's behavioral characteristics: (check all that apply)

☐ Aggressive/Destructive	☐ Attentive	☐ Cooperative
☐ Easily Distracted	☐ Easily Frustrated	☐ Fearful of strangers
☐ Impulsive	☐ Inappropriate Behavior	☐ Plays alone
☐ Poor eye contact	☐ Restless	☐ Short attention span
☐ Self abusive behavior	☐ Separation difficulties	☐ Stubborn
☐ Transition difficulties	☐ Tries new activities	☐ Withdrawn

☐ Other:_____

Do you have any other additional behavior concerns?:

_____
_____
_____

Sleep Patterns

Does your child demonstrate difficulty with any of the following?

☐ Falling asleep alone	☐ Falling asleep
☐ Settling down	☐ Sleeping through the night
☐ Waking up	☐ Other: _____

Bedtime:		Hours per night:	
Naptime(s):			

Self-Care/Daily Routines

Please describe your child's morning routine (level of independence, like/dislike):

_____
_____
_____

Please describe your child's bedtime routine (level of independence, like/dislike):

_____

_____

_____

Is your child toilet trained? ☐No ☐Yes If so, when did this occur? _____

Feeding

Do you have concerns regarding your child's diet, feeding and/or drinking? ☐No ☐Yes

If *YES,* what are the feeding concerns you have with your child? When did they begin?

_____

_____

Has your child had any previous feeding assessments, studies or treatment? If YES, please list the frequency, duration, location, etc.

_____

_____

School

If your child is in school, please answer the following:

Name of school: _____ Teacher's Name: _____

Current grade: _____ Has your child repeated a grade? ☐No ☐Yes

If *YES,* which grade was repeated and why? _____

_____

Has your child ever received services through any of the following school accommodations:

☐ Individual Education Plan (IEP) ☐504 Plan ☐RTI

If *YES,* please list any accommodations and/or services your child receives (aid, therapy services, extended school year, testing accommodations, etc.)

_____

_____

_____

_____

Any other pertinent information you'd like to share:

_____

_____

_____

Kids Unlimited SM
THERAPY SERVICES, LLC

RELEASE OF INFORMATION

I authorize the exchange of Protected Health Information (PHI) between Kids Unlimited Therapy Services, LLC and the specified individuals listed below regarding _____:

Primary Care Physician:

Doctor's Name: _____ Phone: _____

Practice Name: _____ Fax: _____

Address: _____

Specialists/Other Physicians:

Specialty Doctor/Clinic: _____ Phone #: _____

Specialty Doctor/Clinic: _____ Phone #: _____

Specialty Doctor/Clinic: _____ Phone #: _____

School/Therapists:

Preschool/School District: _____ Phone #: _____

Email Address: _____ Fax #: _____

Therapist: _____ Phone #: _____

Email Address: _____ Discipline: _____

Therapist: _____ Phone #: _____

Email Address: _____ Discipline: _____

Therapist: _____ Phone #: _____

Email Address: _____ Discipline: _____

Emergency Contacts (other than parents):

Emergency Contact 1: _____ Relation: _____

Address: _____ Phone: _____

Emergency Contact 2: _____ Relation: _____

Address: _____ Phone: _____

_____ _____

Child's Full Name Date of Birth

_____ _____ _____

Parent/Guardian Name (Print) Date Signature of Parent or Guardian

_____ _____ _____

Parent/Guardian Name (Print) Date Signature of Parent or Guardian

Kids Unlimited SM
THERAPY SERVICES, LLC

COMMUNICATION & CORRESPONDENCE AGREEMENT

WE WILL SHARE YOUR CHILD'S PROGRESS, AS WELL AS DISCUSS OTHER INFORMATION ABOUT YOUR CHILD'S TREATMENT AFTER THEIR SESSION.

We want to ensure your child's privacy and be considerate of any confidential information that may be part of this discussion. A review of the session will take place in one of the waiting areas, or if requested, more privately in a hallway.

We offer helpful administrative information by regular text messaging and email. There is some level of risk that information in a regular text message or email could be read by someone besides you. Please let us know if you would like us to communicate with you by text

☐ Yes - Please communicate with me by email. I will let you know right away if my email address changes.
My email address is: _____

☐ No - Please do not communicate with me by regular (unencrypted) email

☐ Yes - Please communicate with me by text message. I will let you know right away if my cell phone number changes. My cell phone number is: _____

☐ No - Please do not communicate with me by regular (unencrypted) text message

I agree to receive communication from Kids Unlimited Therapy Services, LLC through the above methods. I understand I am responsible for additional data charges imposed by my service provider and acknowledge Kids Unlimited Therapy Services, LLC is not liable for any compromised privacy by my email provider/host, Internet service, cell-phone or data service.

_____ _____
Child's Full Name Date of Birth

_____ _____ _____
Parent/Guardian Name (Print) Date Signature of Parent or Guardian

_____ _____ _____
Parent/Guardian Name (Print) Date Signature of Parent or Guardian

Kids Unlimited SM
THERAPY SERVICES, LLC

PAYMENT POLICY AND PROCEDURES

Insurance

- Fees are submitted to all insurance companies.
- Kids Unlimited Therapy Services, LLC is a provider for Blue Cross/Blue Shield PPO & Blue Choice.
- All other insurance companies pay claims at their out-of-network rates. After the insurance payment is received, parents will be invoiced monthly for any fees not covered by their carrier.
- To expedite the billing process:
  - Parents are responsible for preauthorization and determination of eligibility/benefits.
  - Please provide your insurance company with any necessary paperwork.
  - Please notify Kids Unlimited Therapy Services, LLC immediately of any change in your insurance carrier or your insurance coverage.

Method of Payment

- Invoices will be provided monthly.
- Payment can be made by cash, check, Zelle, Chase QuickPay, PayPal, or credit card.
- Please make checks payable to *Kids Unlimited Therapy Services, LLC.*

Late Payments

- If you have difficulty making payments, a payment plan can be arranged.
- Accounts more than one month in arrears may result in termination of therapy.
- A monthly $10 administrative fee will be charged until balance is paid in full.

SUMMARY OF CHARGES (subject to change without notice)

$220/session	ST Evaluation/Re-Evaluation with short summary report
$285/session	OT Evaluation/Re-Evaluation with short summary report
$100/session*	ST Treatment. Session cost may be higher if multiple procedures are used by therapist
$185/session	OT Treatment
$50 per hour	Additional requested SLP/OT Documentation (including, but not limited to, physician reports, school reports, and insurance documentation- typically 2 hour charge)
$50 per hour	Parent/school meetings or school observations. **Not covered by insurance.**
$50/incident	Missed individual appointment without 24-hour notification. **Not covered by insurance.**
$35/incident	Late arrival of 10 minutes or more after scheduled session start time. **Not covered by insurance.**
$35/incident	Late pick up of 5 minutes or more after scheduled session end time (at conclusion of direct therapy). **Not covered by insurance.**
$35/15 min	Phone calls with parents/other professionals longer than 15 minutes. **Not covered by insurance.**

ADMINISTRATIVE POLICIES

Therapy sessions	A session is one hour (50 minutes direct, 10 minutes for transition, closure, and documentation)
Sick Children	A child may not receive therapy if he or she is sick. A child who has been ill must be fever-free, vomit-free, and diarrhea-free for 24 hours prior to his or her appointment.
Cancellation	Cancellation requires 24-hour notice. A fee will be charged for failure to provide this notice.
Attendance	Required to attend 75% or more of scheduled sessions in one month. If unable to maintain consistent attendance, may result in termination of therapy.
Pick up/Drop Off	Sessions that begin late and/or end after scheduled time due to parent tardiness is subject to additional fees and/or removal from therapist schedule.

I understand and agree to these Policies and Procedures, and I am responsible for all therapy charges.

_____ _____

Child's Full Name Date of Birth

_____ _____ _____

Parent/Guardian Name (Print) Date Signature of Parent or Guardian

_____ _____ _____

Parent/Guardian Name (Print) Date Signature of Parent or Guardian

Kids Unlimited SM
THERAPY SERVICES, LLC

CHILD PICK UP RELEASE FORM

THE FOLLOWING ADULTS ARE AUTHORIZED TO PICK UP MY CHILD FROM KIDS UNLIMITED THERAPY SERVICES, LLC:

1. Parent/Guardian (please print)_____

Cell Phone: _____ Home/Work Phone: _____

2. Parent/Guardian (please print)_____

Cell Phone: _____ Home/Work Phone: _____

PERSON(S) OTHER THAN PARENT/GUARDIAN AUTHORIZED TO PICK UP CHILD:

1. Name (please print) _____

Cell Phone: _____ Relationship: _____

2. Name (please print) _____

Cell Phone: _____ Relationship: _____

3. Name (please print) _____

Cell Phone: _____ Relationship: _____

In case of a last-minute change or addition, please send a note/email authorizing your child's release to the new person and including the dates for which permission is given. Email authorization is accepted from a parent/guardian's email address that we already have on record.

_____ _____

Child's Full Name Date of Birth

_____ _____ _____

Parent/Guardian Name (Print) Date Signature of Parent or Guardian

_____ _____ _____

Parent/Guardian Name (Print) Date Signature of Parent or Guardian

Kids Unlimited SM
THERAPY SERVICES, LLC

RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNITY AND PARENTAL CONSENT AGREEMENT ("AGREEMENT")

In consideration of my child(ren) and persons I invite, including relatives and friends ("Others") being permitted to engage in play opportunities in the Waiting Room or Treatment Areas at Kids Unlimited Therapy Services, LLC ("KUTS") located at 820 North Boulevard, Oak Park, IL 60301, ("Premises"), I agree that:

1. Use of the treatment areas by Others at the Premises is at the discretion of the treating therapist and KUTS;

2. The presence of Others in treatment/waiting areas requires constant supervision by their parent or designated caregiver;

3. The use of equipment, toys and clinic areas holds risk of injury or death to me and Others; and

4. Any circumstances or behavior deemed unsafe or inappropriate by the treating therapist or staff will result in the withdrawal of these use opportunities.

5. Any person not in the waiting areas, must always be accompanied by the treating therapist.

5. I also release KUTS and waive any claims I might otherwise have, if I am injured while in a treatment area with either my child named below, or with Others I have invited to a clinical session.

I HEREBY ACKNOWLEDGE THAT I HAVE READ THIS AGREEMENT AND FULLY UNDERSTAND ITS TERMS AND AGREE TO ABIDE BY THEM FOR THE DURATION OF TIME THAT MY CHILD RECEIVES SERVICES AT KIDS UNLIMITED THERAPY SERVICES, LLC.

_____ _____

Child's Full Name Date of Birth

_____ _____ _____

Parent/Guardian Name (Print) Date Signature of Parent or Guardian

_____ _____ _____

Parent/Guardian Name (Print) Date Signature of Parent or Guardian

Kids Unlimited SM
THERAPY SERVICES, LLC

AUTHORIZATION TO RECORD IMAGES
INCLUDING STILL PHOTOGRAPHS AND VIDEO

The undersigned hereby authorizes Kids Unlimited Therapy Services LLC, ("KUTS") 820 North Blvd, Oak Park, Illinois 60301 to produce visual images whether digitally or otherwise recorded as still photographs or videos, of me, my child(ren) and siblings for the purposes of (1) documenting my child's progress in therapy and (2) education, research or public awareness of the availability of occupational therapy, physical therapy and speech therapy services. I understand that these images may also be used for promotional purposes by KUTS and hereby grant KUTS unlimited use of those images for any of those purposes. This authorization is made with the understanding that the images will not identify me, him or her or any sibling by name.

This authorization shall remain in full force and effect until terminated in writing by the undersigned.

This authorization includes all representations and considerations given me by KUTS and no other inducements or promises have been made to me. I understand that KUTS may not condition my child's treatment, terms of payment, the cost of services or eligibility for services, based upon whether or not I sign this authorization.

☐ Please check here if you do not wish images of you or your child to be made.

☐ Please check here if you wish for images of you or your child only to be made for use of therapy progress and/or parent update.

☐ Please check here if you would consider allowing images of your child to be used for promotional purposes with your prior consent.

☐ Please check here if you would consider allowing images of your child to be used for promotional purposes without your prior consent.

_____ _____

Child's Full Name Date of Birth

_____ _____ _____

Parent/Guardian Name (Print) Date Signature of Parent or Guardian

Kids Unlimited SM
THERAPY SERVICES, LLC

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about your child may be used and disclosed and how you can get access to this information.

How We Use and Disclose Your Health Information

We are required by applicable federal law to maintain the privacy of your child's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your right concerning your health information. We may use and disclose your child's health information as described below, without your authorization. We are required to comply with any state laws that impose stricter standards than the uses and disclosures described in this Notice. This notice takes effect 1/01/04 and will remain in effect until we replace it.

Treatment: We use and disclose your child's healthcare information to provide treatment to your child and to identify the best plan of care for your child, including treatment alternatives, along with needs for special adaptive equipment.

Payment: Your child's information will be used or disclosed to determine the appropriate charges required for the services provided and to receive payment for our services.

Health Care Operations: We may use and disclose your child's health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conduct training programs (including other outside students), accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your child's health information for treatment, payment or healthcare operations, you may give us written authorization to use your child's 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 at any time does not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your child's health information for any reason except those described in this Notice.

Required by Law: We may use and disclose your child's health information as required by law.

Persons Involved in Care: We may use or disclose your child's health information to notify, or assist in the notification of (including identifying or locating) a family member, your child's other legal guardian/personal representative or another person responsible for your child's care on your child's general condition. If you are unable or unavailable to agree or object due to 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 child's healthcare. We may also release information to other healthcare professionals involved in your child's care i.e. physician's, outside therapists, medical rehabilitation equipment providers, etc., using our professional judgment and our experience with common practice to make reasonable inferences of your child's best interest.

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

Public Health: As required by law, we may disclose vital statistics, disease information, information related to recalls of dangerous products and similar information to public health authorities.

Abuse or Neglect: We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, or domestic violence or the possible victim of other crimes. We may disclose your child's health information to the extent necessary to avert a serious threat to your child's health and safety or the health and safety of others.

Health Oversight Activities: We may disclose your child's health information to a health oversight agency for activities including audits; civil administrative or criminal investigations proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law.

Law Enforcement Purposes: We may disclose your child's health information to an order of a court or administrative tribunal. We may also disclose your child's health information in response to a subpoena, discovery request or other lawful process,

but only when reasonable efforts have been made to notify you about the request or to obtain an order protecting your health information.

Serious Threat to Health and Safety: We may, consistent with applicable law, disclose your child's health information if we, in good faith, believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to your child's health or safety or to the health and safety of the public or another person.

YOUR CHILD'S RIGHTS

How We Will Not Use or Disclose Your Child's Health Information

Access: You have the right to request to inspect and to copy your child's information. You must make a request in writing to obtain access to your child's health information

Disclosure Accounting: You have the right to receive an accounting of disclosures of your child's health information made by us, except that we do not have to account for disclosures in this Notice made for purposes of treatment, payment of healthcare operations or disclosures you authorize.

Restriction: You have the right to request restrictions on certain uses and disclosures of your child's health information, however, we are not required to agree to the restriction that you have requested. According to HIPPA specifications, all records will be maintained for a minimum of 6 years from completion of their services. All documents pertaining to your child will be stored in a secured area at all times and disclosed to others with your authorization. After 6 years, all information will be shredded and discarded.

Alternative Communication: You have the right to receive your child's health information through a reasonable alternative means or at an alternative location. You must make your request in writing with specifications regarding the means and location for communication and we may impose a fee for this.

Amendment: You have the right to request that we amend your child's health information in writing to us, that it is incorrect or incomplete. If we deny your request, we will provide you with information about our denial and how you can disagree with the denial.

Electronic Notice: You have a right to a paper copy of this Notice, even if you have received this Notice electronically.

Questions and Complaints:

If you would like a more detailed explanation of these rights, or if you would like to exercise one or more of these rights, contact us using the information listed at the end of this Notice. If you are concerned we have violated any of the above privacy rights, you may complain to us using the contact information listed below this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. 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 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.

Contact: Kids Unlimited Therapy Services, LLC 708-524-2445

Yes, I have received and reviewed the Privacy Notice

_____ _____

Child's Full Name Date of Birth

_____ _____ _____

Parent/Guardian Name (Print) Date Signature of Parent or Guardian

_____ _____ _____

Parent/Guardian Name (Print) Date Signature of Parent or Guardian

Signature above is only acknowledgement that you have received this Notice of our Privacy Practices.

Kids Unlimited SM
THERAPY SERVICES, LLC

Telehealth Consent Form

1. I understand that Kids Unlimited Therapy Services LLC (KUTS), is offering to engage in telehealth sessions with me/my child.
2. KUTS (provider) has explained to me how video conferencing technology will be used to affect such a session, and the session will not be the same as a direct client/provider visit due to the fact that I will not be in the same room as the provider.
3. I understand there are potential difficulties with this technology, including lags, interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the telehealth consult/visit at any time if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my information may be shared with individuals for scheduling and billing purposes.
5. I have had alternatives to a telehealth session explained to me and am choosing to participate in a telehealth session.
6. I understand that my provider will utilize a third-party vendor to provide telehealth communication. This third-party vendor has represented that they are HIPAA compliant, and that all protected health information will remain protected.
7. I understand that charges will be incurred from my provider for this session.
8. I have communicated with my provider and I have had the opportunity to ask questions in regard to this session. My questions have been adequately answered, and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me.
That I fully understand its contents including the risks and benefits of the consultation and services.
That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____	_____
Child's Full Name	Date of Birth

_____	_____	_____
Parent/Guardian Name (Print)	Date	Signature of Parent or Guardian

_____	_____	_____
Parent/Guardian Name (Print)	Date	Signature of Parent or Guardian