PATIENT INTAKE PACKET

Thank you for choosing Feltz Therapy Services, LLC.

Feltz Therapy Services' (FTS) vision is to provide children with lifelong skills. Through compassionate care and therapeutic techniques, children can become successful socially, emotionally, physically, and developmentally. This gives children skills required for play, academics and beyond. We strive to give each child the opportunity to meet their full potential.

We are making a difference…one child at time!

Important: If you are completing these forms on a mobile device, you will need to put it in "desktop mode" in your browser's settings. If you are unsure about how to put it in "desktop mode." Please TEXT our Referral Team at 601.348.5011. Thank you!

Summary of Enclosed Documents

Questions?

Please call or email:

Phone: 615.220.5796, Ext. 1025
Email: referrals@feltztherapy.com

Mailing Address:

1173 Rock Springs Road, Suite 105
Smyrna, TN 37167

FTS CLINIC LOCATIONS

ANTIOCH/SOUTH NASHVILLE: 388 Harding Place, Suite A
GOODLETTSVILLE: 907 Rivergate Parkway, Suite B-1
MURFREESBORO: 520 Highland Terrace, Suite E
SMYRNA: 1173 Rock Springs Road, Suite 105

Our Mission and Vision

Mission Statement

Feltz Therapy Services believes that all children are precious gifts that should be treasured and valued. We strive to provide quality therapy created to serve each child's individual potential. We encourage children to reach attainable tasks and build upon mastered goals while gaining independence in their daily lives. We empower and coach families and caregivers to participate in the therapy journey. It is our goal to inspire children to positively engage and participate in life and the world around them.

Vision Statement

Our vision is to provide children with lifelong skills. Through compassionate care, therapeutic techniques, children can become successful socially, emotionally, physically, and developmentally. This allows them the skills required for play, academics and beyond. We strive to give each child the opportunity to meet their full potential. We are making a difference...one child at time!

Patient Intake Process

1 Initial Referral

Have your pediatrician send a referral and signed doctor's orders via our website or by faxing them to 615.302.2122.

2 Verification of Benefits

We call your insurance provider to get a quote of your benefits, including deductible and out of pocket. A Patient Estimate of Benefits (PEB) will be sent to you outlining your benefits and costs. Insurance verification is not a guarantee of payment.

**TEIS patients will not receive a PEB due to the State covering costs.*

3 Intake Paperwork

We will send you a link to our Patient Portal where you will complete the necessary intake paperwork. When you receive the link, we ask you to fill out and sign our intake paperwork to allow us to treat your child and let you know our policies. Services cannot begin until intake paperwork is completed.

4 Initial Evaluation

Once we receive signed doctor's orders and the intake packet is completed, a representative will contact you to schedule the evaluation. During the evaluation the therapist will evaluate your child. At that time they will determine if therapy is needed and create your child's plan of care.

5 Initial Therapy Session

Once we receive the signed evaluation from your child's doctor, a representative will contact you to schedule recurring therapy sessions based on your child's plan of care.

**If your child is being seen through TEIS, services have to be added to your child's IFSP along with having the evaluation signed by your doctor before therapy can begin.*

CAN TAKE UP TO 2-3 WEEKS

THE TIMELINE FOR SCHEDULING IS DEPENDENT ON PATIENT AND PROVIDER AVAILABILITY.

Please Note: Our experienced therapists use a combination of standardized tests, parent interviews, clinical observations, and their expertise to assess if therapy is warranted for your child and determine the best plan of care. Evaluations are necessary to determine if your child has a delay. With a delay the therapist will give recommendations on the goals that need to be addressed and the frequency of therapy to work on those goals. Goals are measurable and will change as your child progresses. If your child has been evaluated by another therapist within the past year prior to receiving services, a new evaluation may not be necessary. However, the doctor will have to sign the previous evaluation prior to therapy being scheduled.

Person Completing This Form

Full Name _____ Today's Date _____

Relationship to Child _____ Who Referred You to FTS _____

General Patient Information

Child's Information

Child's Full Legal Name _____ Child's Date of Birth (mm/dd/year) _____

Child's Nickname _____ Child's Gender _____

Home Address _____ City/ST/Zip _____

Child's Current Grade _____ Name of School _____

Child Lives with (check one)

- ☐ Both Parents
- ☐ One Parent
- ☐ Foster Parents
- ☐ Parent & Step-Parent
- ☐ Adoptive Parents
- ☐ Other:

Why did you bring your child to FTS for an evaluation?

What therapy goals do you have for your child?

Pediatrician Information

Pediatrician Full Name _____

Pediatrician Phone _____ Pediatrician Email Address _____

Parent/Guardian's Information

Primary Contact

Full Name _____

Date of Birth _____

Occupation _____

Email Address _____

Relation to Child _____

Secondary Contact

Full Name _____

Date of Birth _____

Occupation _____

Email Address _____

Relation to Child _____

Billing Address Information

Street Address_____ City_____

State_____ Zip Code_____

Communication

Please check if it is okay to leave a message	Yes	No		Yes	No
Home Phone_____	☐	☐	Home Phone_____	☐	☐
Cell Phone_____	☐	☐	Cell Phone_____	☐	☐
Work Phone_____	☐	☐	Work Phone_____	☐	☐

Communication Authorization

Email

☐ I give permission to Feltz Therapy Services, LLC (FTS) to correspond with my child's legal guardians and care team via e-mail regarding treatment, documentation, and home programming. I understand that FTS e-mail is encrypted internally; however, once an email is sent externally, correspondence may potentially be intercepted by an outside party.

Text

☐ I authorize Feltz Therapy Services, LLC (FTS) to send text messages to my cell phone related to my child's therapy. I understand that communication via text message is not secure and may potentially be intercepted by a third party. I understand that standard data and text messaging rates will apply to any messages received from FTS. I agree not to hold FTS liable for any electronic messaging charges or fees generated by this service.

By signing below, I authorize Feltz Therapy Services, LLC to contact me via the "Communication Authorization" options I chose above.

Patient Name_____ **Patient's Date of Birth**_____

Parent/Guardian Signature_____ **Date**_____

Information For Our Patients of Divorced Parents

All of us at FTS care about your children and your family and understand that divorce is a stressful time for any family. Please understand that our goal in presenting these guidelines is to provide the highest possible level of care for our patients. It is imperative that we care for your child(ren) in an open atmosphere where information is shared with both parents.

Information Sharing

Under Tennessee law, both parents are entitled to information about their child(ren) unless a court order specifically bars a parent from such information. We expect both parents to communicate with each other regarding their child's health and medical history. It is not the responsibility of our office to provide information to each parent separately because the parents do not communicate with each other. Our therapist's responsibility is to provide therapy and as such they will remain impartial to either parent and will not take sides in any parental dispute.

Information of File

The address listed first for your child (ren) should be the address at which the child resides. If parents share custody and the child resides at two different addresses, please list the address of the parent providing insurance coverage first, followed by the address of the other parent. Please don't eliminate the "other" parent by listing a step-parent instead, as this prevents us from keeping appropriate information on file when both parents are entitled to information about their child(ren).

Patient Name Change or Adoptions

If an adoption is finalized, and the name of the child is changed, it is the adoptive parent's responsibility to provide us with a copy of the final adoption papers reflecting the child's updated name and insurance information under the new name. A new intake packet must be completed as well.

Financial Responsibilities

Both parents are responsible, and payment is due at the time of service. Parents can settle payment disputes outside of the clinic. Whoever brings the child to therapy is responsible to pay at that time. We will give the parent who pays a copy of the payment receipt, and they can use the receipt as proof of payment. We do not provide duplicate statements nor are we responsible for notifying more than one parent of account delinquency. Payment responsibility is a decision of the court and cannot be negotiated by us.

We sometimes find that a parent has been deceptive regarding payment responsibility, the address at which the child resides, custody arrangements, etc. We reserve the right to dismiss the family from our practice if we feel a parent has been deceptive regarding information shared with our office.

Patient Name: _____

Insurance - please provide insurance card(s)

Name of Primary Insurance Provider_____ID #_____

Insured Name_____Insured Date of Birth (mm/dd/year)_____

Employer_____

Name of Secondary Insurance Provider_____ID #_____

Insured Name_____Insured Date of Birth (mm/dd/year)_____

Employer_____

Direct Assignment of Insurance Payment

Please bill my insurance: When Feltz Therapy Services, LLC (FTS) files for third party insurance payment under my policy benefits, and they are otherwise payable to me as the policyholder, I authorize payment directly to FTS. If my policy prohibits direct payment to a doctor or treatment facility, the payment should be made to me as the policyholder, and I agree to reimburse the full amount to FTS. This is a direct assignment of rights and benefits under my insurance policy. Further, I agree to pay Feltz Therapy Services, in a timely manner, any balance that remains after payment of insurance benefits. A photocopy of this assignment shall be considered as effective as the original.

If my insurance coverage changes, I understand that it is my responsibility to inform FTS of my new insurance. I also understand that is my responsibility to keep my insurance company up to date on any coordination of benefits - whether it is the existence of another insurance policy on my child, the termination of another secondary insurance or that the child does not have any other insurance. Presentation of insurance card is permission to bill insurance unless a written denial of access has been submitted.

I have read and understand all of the above, and I agree to all of the conditions and information. I understand that this agreement will remain in effect for the duration of treatment, and that I can revoke this agreement at any time in writing, except for services that have already been provided.

_____ _____

Signature of Policyholder/Legal Guardian Responsible for Payment **Date**

-OR-

Self-Pay: (Sign the following section ONLY if you wish to be self-pay for services; otherwise, leave blank.)

I request that I, in accordance with the Health Insurance Portability and Accountability of 1996 ("HIPPA"), 45CFR 164.522 that Feltz Therapy Services Therapy NOT contact my insurance carrier. I understand I WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICES. If payment is not made at the time of service, the appointment will be cancelled, and a $30 cancellation fee will be added. In order to be self-pay, a credit card must be kept on file.

Please list the therapy type(s): _____

_____ _____

Signature of Policyholder/Legal Guardian Responsible for Payment **Date**

FTS Insurance 101: A Guide to Understanding the Lingo

What is COB?
COB stands for Coordination of Benefits. Insurance companies periodically require confirmation of other policies. The insurance company sends a questionnaire asking for other medical coverage information. If the questionnaire is not returned, even if you do not have any other insurance policies, the insurance company will not pay any claims until the COB is updated. To expedite the process, you can call the insurance company directly and update the information. Be sure to ask for the confirmation number and name of the representative you spoke with.

What is a Deductible?
This is the total amount you as a member must pay out-of-pocket before your insurance starts to pay. For example, if your deductible is $1,000, then your insurance won't pay anything for services until you have paid $1,000 toward services that are subject to the deductible. Keep in mind that the deductible may not apply to every service you receive. Furthermore, even after you've met your deductible, you may still owe a copay or co-insurance for each visit until you meet your out-of-pocket.

What is a Copay?
This is a fixed amount that you must pay for a covered service, as defined by your health plan. Copays usually vary for different plans and types of services. Typically, you must pay this amount at the time of service. Again, copay amounts are fixed - which means you will always pay the same amount, regardless of visit length. In most cases, copayments go toward your deductible.

What is Coinsurance?
This type of payment is calculated as a percentage of the total allowed amount for a particular service. In other words, it's your share of the total cost. For example, let's say:

- Your insurance plan's allowed amount for an office visit is $150, you've already met your deductible, and you're responsible for a 20% coinsurance.
- In this situation, you'd pay $30 at the time of service. The insurance company would then pay the rest of the allowed amount for that visit. Keep in mind that the coinsurance amount may vary from visit to visit depending on which services you receive.
- If you haven't met your deductible, you pay the full allowed amount of $150.

What is Prior Authorization?
Prior authorization - sometimes called preauthorization or precertification - is a process by which health care providers must obtain advance approval from their insurance company before a specific service is provided. S

What is Maximum Out of Pocket?
What you pay toward your plan's coinsurance and copays are applied to your out-of-pocket maximum. This is designed to limit your healthcare expenses throughout the year. Once you reach your out-of-pocket max, your plan pays 100 percent of the allowed amount for covered services. Some insurance plans will include your deductible, copay and coinsurance amount in the out-of-pocket max, and some will not.

What are Max Visits?
Max Visits are when the patient has used their maximum allowed number of visits for the plan year.

What are Combined Visits?
Sometimes your insurance combines visits for various therapies as one total max allowable for the year. The combination can be 2 types of service (such as PT and OT), or it can be all three types of service (OT, PT, ST).

What is a Calendar Year Plan?
Most insurance companies typically base it on a regular calendar year. However, some use a year based on when the company adopted the insurance.

What is a Benefit Exclusion?
A benefit exclusion refers to a service that your insurance company will not cover. It can also have restrictions or limitations for coverage based on the patient's diagnoses.

As difficult as it can be to understand the ins and outs of insurance, it is essential that you know your insurance benefits.

Financial Policy

Feltz Therapy Services' Patient Financial Policy is as follows:

- You are required to present a current insurance card.
- All deductibles, co-payments, co-insurance and estimated patient balances are due at patient check-in. It is the policy of your insurance carrier, and of this office, that all co-pays be paid at the time of service.
- A credit card must be kept on file for all patients receiving offsite services.
- If a patient balance should occur after insurance billing, a patient statement will be sent. Payments must be received on any balances upon receipt to keep your account in good standing.
- No account with balances over $250 can receive services until written arrangements for payment have been made with the Payment Accounts Specialist. A minimum of 25% of the original outstanding bill must be paid each month.
- If you must cancel an appointment, please contact our office at least 24 hours before your scheduled appointment time. A no-show or late cancellation fee will be assessed if advance notice is not provided. Excessive no-shows will result in termination of services.
- Due to the many complicated issues that arise due to custody and payment issues, it is office policy that payment is expected by whichever parent is bringing the child to treatment sessions. Parents may then work out an agreement for repayment among themselves.

ABA Addendums:

- A credit card must be kept on file for all ABA services.
- ABA Evaluations require payment of ½ of the total evaluation fee prior to services.
- Payment arrangements for ongoing services can be made with our Billing Department. If you are unable to pay for services in full, written payment arrangements must be put in place. Payment amounts will be determined on various factors such as deductible amounts, number of months left in the year, etc.

Commercial Insurance Carriers: We bill most insurance carriers for the patients if proper paperwork is provided to us. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. It is your responsibility to understand your insurance benefits. If you are not sure if a service or treatment is covered, you should contact your insurance carrier. If an insurance carrier has not paid within 60 days of billing, the parent or guardian will be billed for services in full which is due upon receipt. You are responsible for charges not paid by your insurance carrier (which would include any claims denied or any claims not paid in full.) If a claim is denied you will need to contact your insurance carrier to dispute the denial or how the claim was processed. If an appeal needs to be filed, the parent will be responsible for filing the appeal and all charges will be due in full. Charges will not be suspended while an appeal is being reviewed. If the appeal is approved and benefits are paid, a refund will be issued to the patient on a per claim basis. Upon confirmation and approval of refund, a check will be issued to the account holder.
If you choose to deny access to your insurance, you must sign an agreement that will be filed in your child's patient record.

Methods of Payment: Our office accepts cash, personal checks, MasterCard, Visa, and Care Credit. Credit card payments can be made over the telephone. A $50.00 NSF charge is incurred for all returned checks. A cash or credit card payment covering the check plus NSF charge must be paid within two weeks or a bad check will be reported to the local district attorney's office checks. Termination of Services: Any patients with an outstanding balance, without a written plan of payment or where a written plan has been violated and is over 60-days past due, will receive a notice of termination of their health care relationship with Feltz Therapy Services, LLC. This termination will be due to a breakdown in professional arrangements whereas financial obligations have not been met.
Termination of the relationship will be 30 days from the date of this notice. Payment of account in full or written payment arrangements with Patient Accounts Specialist can void that termination.

Collection Agency: If services are not paid according to the terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections the patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

The parent or guardian is ultimately responsible for all charges for services.

I have read, understand, and agree with the "Financial Policy" of Feltz Therapy Services, LLC.

Patient Name_____ **Patient's Date of Birth**_____

Parent/Guardian Signature_____ **Date**_____

Authorization for Credit Card Use

All information will remain confidential.

Billing Information

Name as it Appears on Card_____

Billing Address_____ Billing City_____

Billings State_____ Billing Zip Code_____

Cardholder's Phone Number_____

Credit Card Information

Type of Credit Card: ☐ Visa ☐ Mastercard

Credit Card Number_____

Expiration Date_____ CVV (located on the back of the card)_____

Authorization

I authorize Feltz Therapy Services, LLC (FTS) to charge this credit card for the deductibles, co-payments, coinsurance, charges incurred from insurance denials, no-show/cancellation fees, or any other applicable charges related to services provided to my child.

It is my responsibility to update FTS if there are any changes associated with the credit card information provided.

_____ _____

Patient Name **Patient's Date of Birth**

_____ _____

Cardholder's Signature **Date**

CONSENT AND AUTHORIZATION FORMS

Permission to Treat

I consent for my child to receive evaluation and/or therapy services, in person and via teletherapy, from Feltz Therapy Services, LLC (FTS) and their treating therapists according to my child's orders. I agree that FTS providers or administrative staff may take my child to the restroom and supervise, help, or provide diaper changes as needed. I understand that sometimes minor injuries such as cuts, bumps etc. can occur during the course of treatment. I give FTS permission to treat my child for minor injuries. If my child needs emergency medical care while receiving services, I give permission to Feltz Therapy Services or their treating therapists to administer or obtain such care, and I agree to be financially responsible for the services.

Caregiver Information

I authorize Feltz Therapy Services, LLC to allow the following people, other than the parent/guardian, to pick up by child from clinic appointments and to receive a report of progress during the appointment.

Caregiver #1

_____ _____

Full Name and Relation to Child **Phone**

Caregiver #2

_____ _____

Full Name and Relation to Child **Phone**

Authorization of Release of Information

I hereby authorize Feltz Therapy Services, LLC (FTS), and/or their treating therapists to obtain/release information, as necessary, for the purpose of filing for insurance compensation or for requesting compensation from Federal or State resources that appropriate payment for services my child receives.

I understand that in order for my child to be provided with the best possible services, FTS must have my permission to communicate with other parties/providers involved in my child's care such as teachers, school therapists, ABA providers, etc. involved in my child's care. I hereby grant permission for FTS and their treating therapists to obtain/share information with the agencies/persons listed below.

Please list the names of all physicians, practices, and agencies that are involved in your child's care.

Open Gym Consent

FTS has an open therapy gym where our therapists may use larger equipment or spaces to target your child's individualized goals. Your child may be receiving therapy in the open gym area where other children are engaging in therapy activities. Your child may interact with other children and therapists (if your therapist thinks it would be beneficial to your child's treatment). Additionally, other parents/children in the gym may overhear your therapist talking to you and your child during the therapy session, which may include your child's name and progress. If you have any concerns about this, please talk to your child's therapist.

College and University Partnerships

FTS understands the need to train professionals in the field of occupational, physical, and speech therapy. We partner with local colleges and universities whose students observe and take part in our therapy sessions under the supervision of our certified therapists. We will inform you if there will be a student involved in your child's therapy session and you have the option to request another therapist. If you have any concerns about this, please talk to your child's therapist.

I have read, understand, and agree to the "Consent and Authorization Forms" above. This agreement will remain in place until revoked in writing.

Patient Name_____ **Patient's Date of Birth**_____

Parent/Guardian Signature_____ **Date**_____

Media Consent

FTS will occasionally ask to use photos/audio/video of our patients for educational purposes or to allow the public to be informed of our services and activities. We would appreciate your permission for this use. Names will remain anonymous unless otherwise specified by you.

Photographs
I give permission to FTS to take and use photographic images for the following purposes (check all that apply):
☐ Training and/or educational purposes
☐ Use in marketing materials of Feltz Therapy Services, LLC (e.g., website, blog, brochures, social media)

Audio Recordings
I give permission to FTS to take and use audio recordings for the following purposes (check all that apply):
☐ Training and/or educational purposes
☐ Use in marketing materials of Feltz Therapy Services, LLC (e.g., website, blog, brochures, social media)

Video Recordings
I give permission to FTS to take and use video recordings for the following purposes (check all that apply):
☐ Training and/or educational purposes
☐ Use in marketing materials of Feltz Therapy Services, LLC (e.g., website, blog, brochures, social media)

☐ I hereby waive any rights to royalties or compensation arising from or related to the use of the media. I understand that I may address any specific questions regarding this release by contacting FTS at info@feltztherapy.com.

Deny Permission
☐ I DO NOT give permission to FTS to take and use video recordings for any purpose.

By signing below, I authorize Feltz Therapy Services, LLC to the "Media Consent" options I chose above.

Patient Name_____ **Patient's Date of Birth**_____

Parent/Guardian Signature_____ **Date**_____

Patient Code of Conduct

To provide a safe and healthy environment for patients, staff and visitors, Feltz Therapy Services expects visitors, patients, and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

The following behaviors are prohibited:

- While we strive to provide great patient care, rude, hurtful, offensive language, or hostile behavior toward staff members, or any other visitor will not be tolerated and will be considered grounds for dismissal.
- You may be asked to leave the premises immediately, for any behavior that violates this code of conduct.
- Making harassing, offensive, or intimidating statements, or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal, or electronic communication.
- Any sexually harassing conduct. Including, but not limited to:
    - Sexual flirtations, advances, or propositions;
    - Verbal or written abuse of a sexual nature;
    - Graphic verbal comments about an individual's body;
    - Sexually degrading words used to describe an individual;
    - Displaying in the workplace sexually suggestive objects or pictures;
    - Telling jokes of a sexual nature or making sexual innuendoes;
    - Unwelcome or offensive touching, hugging, rubbing, patting, pinching, or kissing another person; and
    - Pressuring an employee for a date or sexual activities and/or sexual assault.
- Possession of firearms or any weapon
- Physical assault, arson, or inflicting bodily harm.
- Making verbal threats to harm another individual or destroy property.
- Intentionally damaging equipment or property
- Making menacing or aggressive gestures
- Racial or cultural slurs or other derogatory remarks associated with, but not limited to age, race, language, or sexuality.

To ensure that the privacy of our patients and staff is protected and to ensure that the physician-patient relationship remains confidential and private, Feltz Therapy does not permit anyone to record, video tape or photograph without permission.

Only trained service animals are permitted in the clinic.

Family members, and any minors that are not receiving services, should be always accompanied by an adult.

If this behavior occurs while services are being performed at home, daycare, etc., the rendering therapist will end services and leave the site immediately. Services could be discontinued, and children may be discharged. If you have any questions or concerns, please contact us at info@feltztherapy.com.

I have read, understand, and agree to the terms of the “Patient Code of Conduct.”

Patient Name_____ **Patient’s Date of Birth**_____

Parent/Guardian Signature_____ **Date**_____

Attendance Policy

As a health care provider our office understands that you, as a parent or guardian, have many choices in providers and we are pleased that you have selected our office for your child's healthcare needs. We are committed to providing top quality therapy services to your child. With this commitment we believe a clear understanding of our attendance policy is imperative.

Therapy is a physician-ordered service which directs the frequency of sessions that need to occur each week/month. Attendance at each session is vital to ensure your child makes progress towards his/her established goals. It is extremely important that your child receives therapy on a consistent basis.

1) If you must cancel an appointment, please contact our office at least 24 hours before your scheduled appointment time. If parent/guardian fails to contact FTS, it will be considered a "NO SHOW" and you will be responsible for a No Show/Late Cancellation Fee. Please note: If your child is receiving more than one therapy (ie: OT & PT) on the same day and you NO SHOW for both, you will be billed $30 for EACH therapy session missed. Please note: TEIS and Medicaid patients see #3.

2) If a TWO CONSECUTIVE NO SHOWS occur, you will be charged the $30 No Show/Late Cancellation Fee and you will be notified in writing that your child will be DISCHARGED from therapy. Your child's physician will also be notified services have been discontinued due to lack of consistency.

3) TEIS and Medicaid policies do not allow for billing of No-Show Fees; however, all other Attendance Policy guidelines apply to your child. FTS is required to notify the TEIS coordinator if a family misses 2 visits in a row or 3 visits in a within 90-days. Your Service Coordinator will contact you regarding the absences and discuss possible solutions.

4) If your child will be more than 10 minutes late for his/her scheduled one-hour session, or 7 minutes late for his/her scheduled 30-minute session, please contact the clinic where the appointment is scheduled, or your therapist, to let them know. Therapists are scheduled with back-to-back appointments and cannot accommodate patients who are late. Therefore, the appointment will be cancelled and a $30 no show/late cancellation fee charged. Please note: TEIS and Medicaid patients see #3.

5) If tardiness persists or your child falls below an 80% attendance rate, your child will lose his/her standing appointment. The therapist will place your child on the FIT Schedule. You will be offered available times or your child will be placed on a waiting list. Otherwise, your child will be discharged. Please note: Emergency situations beyond your control will not be considered cancellations. Please communicate with our staff when any unforeseen issues arise, in order for us to work with you.

6) If your child has been discharged from therapy due to inconsistent attendance/no shows and you wish to resume therapy services, all outstanding charges must be paid in full, and he/she must wait a minimum of six months before a new referral will be accepted. We cannot guarantee your child's original therapist, appointment day, or time once he/she has been removed from the therapist's regular schedule.

I have read, understand, and agree to the terms of the "Attendance Policy."

Patient Name_____ **Patient's Date of Birth**_____

Parent/Guardian Signature_____ **Date**_____

Patient Rights & Responsibilities

Patients have a fundamental right to considerate care and treatment that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values. In recognizing these values, the following procedure has been developed for Feltz Therapy Services, LLC.

Patient Rights

- All patients will be provided with a copy of the Patient Rights and Responsibilities.
- The patient has the right to a reasonable response to his/her treatment needs and requests for service. The care provided by the therapist must be within the organization's stated mission and capacity, as well as applicable law and regulation.
- The patient has the right to be free from all forms of abuse or harassment.
- The patient has the right to access protective services.
- The patient, regardless of race, sex, religion, disability, creed, age, or source of payment shall have the right to receive respectful and considerate care. FTS recognizes that the patient has individual psychosocial, spiritual, and cultural needs and values, which may affect his/her response to the care given. Every consideration is given to accommodating these needs.
- The patient has the right to express spiritual beliefs and cultural practices, provided such activities do not harm others. This includes the right to wear appropriate personal clothing and religious or other symbols and items.
- The relationship between the patient and his/her therapist represents a unique partnership. It is recognized that the patient has a right to express opinions and to participate in decisions pertaining to the provision of health care service within the clinic. If the patient is a child or adolescent, the parent(s) or legal guardian(s) shall have the right to participate in the decision-making process on behalf of the patient. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of such refusal. Should the refusal of treatment by the patient or his/her legally authorized representative prevent the provision of appropriate care in accordance with ethical and professional standards, the therapist-patient relationship may be terminated, upon reasonable notice.
- Patients and/or family will be informed if treatment outcomes differ significantly from anticipated outcomes.
- The patient has the right to know by name and specialty the therapist responsible for his/her care, as well as the name and function of any individual providing services to him/her. The patient has the right to receive from his/her therapist information necessary to give informed consent prior to the initiation of any Feltz Therapy Services treatment.
- The patient has the right to every consideration of privacy and respectfulness concerning his/her medical care program. Case discussion, consultation, examination, treatment, and all protected health information are confidential and should be conducted discreetly. Those not directly involved in the delivery of care must have permission from the patient to be present. Patient treatments are conducted in surroundings designed to give reasonable visual and auditory privacy as much as possible. The patient has the right to privacy and confidentiality of all communications and records pertaining to his/her treatment, except as otherwise provided by law or third payment contract. The patient (or his/her legally designated representative) has access to the information contained in the patient's medical record, within the limits of the law.
- The child and adolescent/minor patients and their parents and or legal guardians shall be afforded the same rights as the adult patients. Minor patients have the right to be attended by a parent, or other responsible adult designated by the parent or legal guardian.
- The patient has the right to expect reasonable continuity of care and shall be informed by his/her therapist or delegate of any continuing healthcare requirements following discharge.
- The patient, regardless of source of payment, has the right to receive an itemized bill and explanation of charges for services rendered and notice of non-coverage.
- The patient has the right to be informed of Feltz Therapy Service's rules and regulations applicable to his/her conduct as a patient. Patients are entitled to information about the clinic's mechanism for initiation, review, and resolution of patient complaints. Patients have the right to freely voice complaints. Complaints may be registered with the office manager or assistant office manager. The patient shall receive communication regarding resolution of the complaint.
- The patient has the right to expect reasonable safety as Feltz Therapy Services' practices and environment are concerned.
- The patient has the right to access information contained in his/her clinical records within a reasonable time frame, including limiting the release of disclosure of patient information.
- The infant/child has the right to receive considerate and respectful care.
- The infant/child has the right to receive the best medical care available regardless of race, age disability, color, creed, or financial ability to pay.

- The infant's/child's parents have the right to receive from the therapist the information necessary to give informed consent.
- The infant/child and his/her family have the right to confidentiality in all communications and records institutions.

Patient Responsibilities

- Patients are responsible for providing Feltz Therapy Services and its practitioners with complete and accurate information regarding present and past illnesses and operations, hospitalizations, medications, and other health-related items, including any unanticipated changes in their condition.
- The patient has the responsibility to provide FTS with updated demographic information, including but not limited to; name changes, address, phone, email, change in pediatrician, etc.
- If an adoption is finalized, and the name of the child is changed, it is the adoptive parent's responsibility to provide us with a copy of the final adoption papers reflecting the child's updated name and insurance information under the new name. A new intake packet must be completed as well.
- A patient is responsible for making it known whether he/she clearly comprehends a contemplated course of action and what expectations should be met.
- The patient is responsible for following the treatment plan recommended by the practitioner primarily responsible for his/her care.
- The patient shall be held responsible for any occurrences resulting from refusal of treatment or failure to follow the therapist's instructions.
- The patient is responsible for assuring that the financial obligations of his/her health care services are fulfilled as promptly as possible.
- The patient is responsible for following Feltz Therapy Services rules and regulations affecting patient care and conduct.
- The patient is responsible for being considerate of the rights of other patients and Feltz Therapy Services personnel. The patient must be assured that his/her visitors are considerate of others, and that unnecessary noise and unreasonable behavior do not annoy other patients. The patient is responsible for being respectful of the property of other persons and of Feltz Therapy Services.
- A parent, legal guardian, or their designee must be present and/or available, dependent on the patient's situation, while a minor is a patient.
- The parent or legal guardian of the child or adolescent patient is responsible for informing Feltz Therapy Services as soon as possible if it is believed that the minor's rights have been violated.

Client Grievances

FTS provides a policy regarding client grievances and complaints: If you have a grievance that cannot be resolved with your therapist, you should document your grievance and forward it to **Feltz Therapy Services, Attn: Operations Manager, 1173 Rock Springs Road, Suite 105, Smyrna, TN 37167 or info@feltztherapy.com**. If you file a complaint, we will not take any action against you or change our treatment of you in any way. To file a complaint with Feltz Therapy Services, LLC, document your complaint in writing along with your full name, address, and phone number and forward it to our privacy officer.

Acknowledgement of Patient Rights & Responsibilities, Code of Conduct, and Client Grievances

I have received a copy of the "Patient Rights & Responsibilities and Client Grievances" and its contents have been explained to me in a manner in which I understand.

Patient Name_____ **Patient's Date of Birth**_____

Parent/Guardian Signature_____ **Date**_____

FTS Practices & Policies

1) **Therapy Sessions**
   - One parent/guardian allowed with child during an evaluation or therapy, as determined by therapist.
   - Sessions are strictly kept to thirty (30) or sixty (60) minutes in length. Within that time the therapist will be documenting the progress your child is making in the session.
   - If present during therapy, address questions at the beginning of a session.
   - The last five (5) minutes of the session the parent/guardian is to meet with the therapist.
   - The parent(s) or responsible adult in attendance is authorized to receive your child's Personal Health Information (PHI).
   - The parent(s) or responsible adult must be present 10 minutes prior to the end of the session.
2) **General Health**
   - Do not bring your child to therapy if your child has:
     - Fever (must be fever free for 24 hours-unmedicated)
     - Excessive coughing and/or nasal discharge
     - Diarrhea
     - Vomiting
     - Any contagious disease (including head lice)
     - Any illness keeping your child from attending daycare or school
     - Your child must be symptom free for 24 hours prior to coming for therapy
3) **Scheduling**
   - Sessions are scheduled through the scheduling department, the therapist's supervisor, or directly by the therapist.
   - Recurring sessions are scheduled weekly on the same day of the week and same time.
   - Occasional requests will be granted for a more convenient time if available.
   - A waiting list is available when needed.
   - After school and after work is the most desirable time for appointments, which may make it difficult to schedule.
4) **Extended Absences (vacation, traveling, etc.)**
   - If a family goes on vacation, no more than two (2) weeks, the child's "time slot" will be retained when documentation has been provided prior to the vacation.
   - However, when a child is absent two (2) or more weeks, your child's appointment time may be given to another child.
     - Please reschedule when you return and understand that if you are absent, without documented consent, you may be put on a waiting list.
     - Two options to assist in getting the time desired to be scheduled:
       - Call-In each week for openings due to cancellations, etc.
       - Place your name on a fit schedule list.
5) **Cancellations Due to Company Closure or Therapist Absence**
   - Notice will be given in advance or as soon as possible (if due to illness).
   - You will be given the option to see another therapist if available.
   - Holidays observed at FTS. Our clinics, and most daycares are closed, however, some home appointments may occur.
     - New Year's Day
     - Good Friday
     - Memorial Day
     - Independence Day
     - Labor Day
     - Thanksgiving Day & Friday After
     - Christmas Day
6) **Waiting Room Guidelines**
   - Minor children cannot be dropped off or left unattended in the lobby.
   - All children must be monitored continuously in the waiting room.
   - Please do not allow child(ren) to climb or jump on chairs, throw toys, slam doors, scream, fight, bite, or engage in any other disruptive behavior. The goal is to prevent injury and to avoid disturbing staff and others in the waiting room.
   - Please do not yell, curse, use offensive language, threaten, belittle, or speak abusively to your child(ren), other adults, staff, or therapist. This would violate our Patient Code of Conduct.
7) **Termination of Services**
   - If you terminate therapy, for any reason, we require at least 2 weeks of sessions' prior written notice in order for the therapist to transition the child out of therapy and complete closure. We reserve the right to terminate our relationship with a client at any time for any reason. Unless circumstances require otherwise, if we terminate the relationship, we will provide at least 2 sessions' prior notice.
8) **Discharge from Therapy -** The following are instances in which a patient is discharged.
     - Treatment goals are met
     - Insufficient progress has been made
     - Inconsistent attendance
     - Non-compliance
     - Behavior interrupts the ability to provide productive therapy or is unsafe for the therapist and/or patient

Clinic Visit Policies

We ask that:

Please reply to text reminders to confirm or cancel.

If your child has been sick, they must be symptom free for 24 hours (diarrhea, fever, vomiting, etc.)

Please notify the front desk or your therapist if you need an interpreter.

Due to back-to-back schedules for therapists, sessions will need to be rescheduled if the family is more than 7 minutes late for a 30 minute session or 15 minutes late for a full session. Please notify the front desk or your therapist if you are running late.

Please be at the clinic 10 minutes before the end of the session to meet with the therapist and pick up the patient.

Please keep a copy of the attendance policy for your reference.

We look forward to serving your family and child!

Notice of Privacy Practices

Effective date: January 1, 2024

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about your minor child (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact: Feltz Therapy Services, Attn: Operations Manager, 1173 Rock Springs Road, Suite 105, Smyrna, TN 37167 or info@feltztherapy.com.

C. We may use and disclose your PHI in the following ways:
The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a DME agency when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our therapists – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in care. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the therapy session. In this example, the babysitter may have access to this child's medical information.
8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

D. Use and disclosure of your PHI in certain special circumstances:
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury, or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying an employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death, we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena, or similar legal process,
- To identify/locate a suspect, material witness, fugitive, or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity, or location of the perpetrator).

5. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:
(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;
(B) The research could not practicably be conducted without the waiver,
(C) The research could not practicably be conducted without access to and use of the PHI.

6. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
7. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
8. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials, or foreign heads of state, or to conduct investigations.
9. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
10. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:
You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Feltz Therapy Services, Attn: Medical Records Request, 1173 Rock Springs Road, Suite 105, Smyrna, TN 37167 or records@feltztherapy.com** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Feltz Therapy Services, Attn: Medical Records, 1173 Rock Springs Road, Suite 105, Smyrna, TN 37167 or records@feltztherapy.com**. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure, or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Feltz Therapy Services, Attn: Medical Records Request, 1173 Rock Springs Road, Suite 105, Smyrna, TN 37167 or records@feltztherapy.com** in order to inspect and/or obtain a copy of your PHI. Our practice does not charge for emailed records. However, we charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. The cost is $20.00 for 5 pages or less, and $0.50 per page for any additional pages. Payment will need to be made in advance by paying in person at one of our clinics, mailing a check or calling and have the cost charged to a credit or debit card. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Feltz Therapy Services, Attn: Medical Records Request, 1173 Rock Springs Road, Suite 105, Smyrna, TN 37167 or records@feltztherapy.com**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment, or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Feltz Therapy Services, Attn: Patient Accounts Specialist, 1173 Rock Springs Road, Suite 105, Smyrna, TN 37167 or PatientBilling@feltztherapy.com**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before November 1, 2017. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Feltz Therapy Services, Attn: Medical Records Request, 1173 Rock Springs Road, Suite 105, Smyrna, TN 37167 or records@feltztherapy.com**.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Feltz Therapy Services, Attn: Operations Manager, 1173 Rock Springs Road, Suite 105, Smyrna, TN 37167 or info@feltztherapy.com**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Feltz Therapy Services, Attn: Operations Manager, 1173 Rock Springs Road, Suite 105, Smyrna, TN 37167 or info@feltztherapy.com**.

For more information see: https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html.
The U.S. Department of Health & Human Services
Office of Civil Rights
2000 Independence Avenue S.W. Washington, D.C. 20201
Toll Free: 1-877-696-6775
HHS.mail@hhs.gov

Acknowledgement of Notice of Privacy Practices

As a client of FTS, you have certain rights regarding your child's services and the protection of you/your child's health care information. "Notice of Privacy Practices" has been given to you today. By signing below, I acknowledge I have received a copy of the "Notice of Privacy Practices" and its contents have been explained to me in a manner in which I understand.

Patient Name_____ **Patient's Date of Birth**_____

Parent/Guardian Signature_____ **Date**_____

☐ **If you are a parent/guardian and you are unable to sign these forms due to a disability or any other limitations and are in complete agreement with all the above statements and regulations, please check this box.**

Writing your name in a signature space will be legally binding as your signature in any of the forms above.