Client Name: DOB: Medicaid ID#

# GRACE C. MAE ADVOCATE CENTER

## CLIENT REGISTRATION FORMS

**Date: _____**

| | | | |
|---|---|---|---|
| Clients Full Legal Name | | Marital status (circle)<br><br>Single Married Separated<br>Divorced Widowed | Social security number |
| Is this your legal name<br><br>Yes No | Preferred name and/or pronoun: | Birth sex Male Female<br>Gender (Circle)<br>Male Female Non-binary<br>Prefer not to say | DOB: Age: |
| Home Address | PO Box | County | Phone# |
| Email Address | Occupation | Employer | Employment status (circle)<br>Full Time Part time<br>Retired Unemployed |
| School Attends | DHS Worker | | Court officer/Probation |

**Complete the following information if the client is under age 18**

| | | | |
|---|---|---|---|
| **Parent**<br><br>Lives with<br>Yes No | Full Name | Street Address (if different from child) | Cell #<br><br>Home #<br><br>Work # |
| | Email Address | | |
| **Parent**<br><br>Lives with<br>Yes No | Full Name | Street Address (if different from child) | Cell #<br><br>Home #<br><br>Work # |
| | Email Address: | | |
| **Current Placement**<br>(Circle)<br>Relative<br>Foster<br>Residential<br>Other | Full Name | Street Address (if different from child) | Cell #<br><br>Home #<br><br>Work # |
| | Email Address: | | |

Important: If anyone other than a parent is signing this form (i.e. a guardian), he or she must produce a signed affidavit/court order from the Court authorizing him or her to sign on behalf of the client. A copy of this affidavit/court order must be kept in the client's file.

How did you hear about us? Website Doctor or other professional GCMAC Employee School Counselor/staff A friend
Other _____

Client Name: DOB: Medicaid ID#

# INSURANCE INFORMATION

Please give your insurance card to the receptionist to be copied

| **PRIMARY PRIVATE INSURANCE** | | | | |
|---|---|---|---|---|
| Policy holder name | | DOB | Street Address (if different from client) | Phone # |
| Policy holders Social Security Number: | Employer: | Is client covered: Yes No | Insurance Company Name | Policy # Group# |
| Clients relationship to policy holder: (circle) Self Spouse Child Other _____ | | | Effective Date: | |
| Policy Holder Email: | | | | |

| **MEDICAID/ HAWK-I/ MEDICARE INSURANCE** Effective Date:_____ | | | |
|---|---|---|---|
| **Circle policy type** HAWK- I MEDICAID MEDICARE PART B | | **Circle MCO** AMERIGROUP IOWA TOTALCARE MOLINA No MCO/IME | |
| Name as it appears on the card | DOB | Medicaid ID # | Medicare Part B ID# |

| **SECONDARY PRIVATE INSURANCE** | | | | |
|---|---|---|---|---|
| Policy holder name: | | DOB: | Street Address (if different from client) | Phone #: |
| Policy holders Social Security Number: | Employer: | Is client covered: Yes No | Insurance Company Name | Policy # Group# |
| Clients relationship to policy holder: (circle) Self Spouse Child Other _____ | | | Effective Date: | |
| Policy Holder Email: | | | | |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Grace C. Mae Advocate Center, Inc. I understand that I am financially responsible for any balance. I also authorize Grace C. Mae Advocate Center, Inc. to release any information required to process my insurance claims. (See Payment Policy).

**Indicate your preference for appointment reminders:**

Phone call to: _____ Is it okay to leave a message? YES NO

Text to: _____ Or same # listed on front of form YES NO

Email to: _____ Or same email listed on front of form YES NO

Appointment reminders are generated from our Cedar Rapids office location, please attend your session at your local GCMAC office.

**TEXTS ARE FOR APPOINTMENT INFORMATION ONLY.**

Grace C. Mae Advocate Center
319-361-6529 Main 319-343-1059 Fax help@advocatecenter.org
www.gracecmae.org
Revised 7/18/23

Client Name: DOB: Medicaid ID#

## Consent for Treatment

By signing this form, I hereby give my consent for evaluation/treatment to be administered to the client listed above by the employees of Grace C. Mae Advocate Center, Inc, with or without my presence. I understand that if I do not revoke my *Consent for Treatment,* it will expire automatically one year from the date of signature.

## Receipt or GCMAC Client Handbook

By signing this form, I am acknowledging that I have been given a hard copy access to a copy of the GCMAC Client Handbook containing the information regarding policies and practices of the Grace C. Mae Advocate Center. The handbook includes but is not limited to; policies about my rights and responsibilities as a client, the therapist role/ therapy process for children, suspected child abuse, dependent adult abuse reporting, client grievance procedures, notice of privacy practices and client rights, DHS and court involvement policy, release of records and progress notes and electronic communication guidelines, attendance expectations, illness policy and more. The client handbook is available for viewing on the Grace C. Mae Advocate Center website at gracecmae.org.

## Cancellation and Attendance Policy

We require a 24 hour notice for all cancellations. Appointments canceled with less than a 24 hour notice are considered a late cancel. If you late cancel or no-show more than two times in a three month period, you will be placed on a same day call in scheduling basis. If you cancel multiple family members who are scheduled on the same day, this may affect your ability to schedule more than one family member per day.

Clients should arrive on time for scheduled appointments. If you arrive more than 10 minutes late, you may be asked to reschedule your appointment. If you are still able to be seen, your session will still end at the originally scheduled end time.

## Video Consent/ Training

GCMAC is a learning agency that offers internships to qualified students who will be working in this field GCMAC uses video monitoring for clinical supervision and learning purposes for both students and staff. Supervision is done through observation of the client session, video recording and clinical consultation in individual and/or group settings. The purpose of the videos are to observe the therapist, not the client. Videos are erased and not stored after being viewed by the supervisor. By initialing this section, I am acknowledging that GCMAC is permitted to video tape my or my child's therapy session Initial Here _____ Decline here

I give permission for intern students/staff in training to sit in during my child's therapy sessions Initial here ____ Decline here

Client/Parent/Guardian Signature _____ Date _____ Relationship to Client _____

Witness Signature _____ Date _____

Client Name: DOB: Medicaid ID#

**PLEASE CAREFULLY READ THE FOLLOWING AND SIGN BELOW**

# OFFICE PAYMENT POLICY

**You will receive a copy of this form in the GCMAC handbook and/or online at gracecmae.org**

You are financially responsible for all charges and for knowing and understanding policies and benefits of your insurance coverage including co-payment/deductible, covered benefits, and prior authorizations procedures.

**Insurance**: We participate in most insurance plans and Medicaid. It is your responsibility to contact your insurance provider regarding what your policy covers for mental health services.

**Co-payments, Deductibles**: All co-payments and deductibles **must be paid at the time of service**, unless prior arrangements have been made with our billing office. Payments can be made by cash, check, Debit card, Flex cards, Health Savings account and Visa/MasterCard. Please note there is a $30 service charge on all returned checks.

**Proof of insurance**: Clients are required to provide a valid photo ID and current insurance card at their initial session and whenever insurance coverage changes. If you fail to provide us with correct insurance information in a timely manner, you will be responsible for the balance of any outstanding claims.

**Claims submission**: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. At times your insurance company may request information from you directly- it is your responsibility to comply with their requests. Please note that it may take 3-4 weeks after your session for our billing office to receive the Explanation of Benefits (EOB) from your insurance provider that shows the amount you are responsible to pay.

**Coverage changes**: If your insurance changes, please notify us before your next visit so we can make the appropriate changes in your chart. We will require you to provide us with the new insurance card, effective date and all updated information.

**Lapse of coverage**: If your insurance coverage ends or lapses, you will be expected to pay minimum of $50 per session until insurance is reinstated, unless prior authorization is obtained by our billing specialist. Services will be suspended without on-going payment arrangements. If these services are later covered by insurance, GCMAC will issue a full refund within 10 days of payments received on account.

**Billing**: You will receive a monthly statement from our billing company. Charges on your account depend on the length of time it takes for some insurance companies to send out the EOB. Please pay your amount due promptly. If your account is over 30 days past due, you will receive a letter stating that you have 10 days to make payment arrangements or pay in full. Please be aware that if your balance remains unpaid and you fail to set up a payment plan, we may refer you to a collection agency and subsequently discharge you/your child from our care.

The party who signs the payment policy document is the person who is responsible, regardless of any other financial or legal arrangements. It is the responsibility of the signing party to obtain additional signatures when needed for sharing or accepting financial responsibility. In the event of a court order or custodial decree, the parent or guardian enrolling a child into services is financially responsible for all account balances. Should the other parent or guardian be required to pay a portion or all of the account balance, then the enrolling parent/guardian should seek reimbursement from that other parent/guardian.

**I authorize** the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim or obtain authorization for treatment/medications from insurance.

**I request** that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, Medicaid, private insurance and other health plans to the Grace C. Mae Advocate Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **TO MY KNOWLEDGE ALL INFORMATION ON THIS FORM IS CORRECT. I AGREE TO THE ASSIGNMENT AND FINANCIAL RESPONSIBILITIES SHOWN ON THIS FORM.**

_____ _____

Client/Parent/Guardian Signature (Will be updated yearly) Date

_____ _____

Staff Witness Date

Grace C. Mae Advocate Center
319-361-6529 Main 319-343-1059 Fax help@advocatecenter.org
www.gracecmae.org
Revised 7/18/23

Client Name: DOB: Medicaid ID#

# Telemedicine Informed Consent

I, _____, hereby consent to my child, _____, to engage in telemedicine (e.g., internet or telephone-based therapy) at the Grace C. Mae Advocate Center as the main venue for my child's psychotherapy treatment. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or date communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I and my child (we) have the following rights with respect to telemedicine:

(1) We have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which we would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, we understand that the information disclosed by me or my child during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where we make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

We also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) We understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner. In addition, we understand that telemedicine based services and care may not yield the same results nor be as complete as face-to-face service. We also understand that if my psychotherapist believes we would be better served by another form of psychotherapeutic service (e.g. face-to-face service), we will be referred to a psychotherapist in my area who can provide such service. Finally, we understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) We understand that we may benefit from telemedicine, but the results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) We understand that we have the right to access my medical information and copies of medical records in accordance with Iowa law, that these services may not be covered by insurance and that if there is intentional misrepresentation, therapy will be terminated. Iowa law prohibits children's session notes from being disclosed to parents or third parties.

Client Name: DOB: Medicaid ID#

(6) I understand that I am responsible for any out-of-pocket expenses not covered by insurance for teletherapy services. Failure to pay these expenses may and can result in termination of teletherapy services and referral to the patient accounts department for collection purposes, which will include additional fees. Payment is expected at the time of service and can be paid with a credit or debit card.
We understand that neither the therapist nor the client will record any teletherapy sessions.

## Telehealth Crisis Plan

In case of an emergency or escalating crisis due to the status of my child's mental health, I understand my therapist may need to contact my designated crisis support system. Releases of information are on file with my signature and consent to contact these supports. However, in addition, my child may need emergency personnel to be called in the event that he/she is escalating to imminent risk. Although this is a rare situation, legal statues and ethical guidelines prohibit teletherapy from occurring without having a written crisis plan, and to have my child's location and phone numbers reviewed at the beginning of each teletherapy session.

My child's emergency contact support person is:

_____ Phone: _____

My child's local non-emergency service number is:
(Therapist cannot call 911 from the originating location)

_____ Phone: _____

We have read and understand the information provided above, which has also been explained to me verbally. We have discussed it with my psychotherapist, and all of our questions have been answered to our satisfaction.

Parent/Guardian signature:

_____ Date: _____

Client signature:

_____ Date: _____

Client Name: DOB: Medicaid ID#

# School Based Therapy/ BHIS Counseling Services Form

**School:** **Grade:** **Teacher:**

Based on recommendations of the mental health treatment team, therapy and BHIS services are recommended to be delivered during school hours for the above named child with the following criteria:

1. Services should not interfere with school instruction if at all possible
2. Coordination of the clinical treatment plan with identified school staff is required
3. BHIS should not be delivered in non-therapeutic settings, i.e. school hallways

Documented reasons indicating that therapy and/or BHIS counseling during school hours would be clinically more beneficial than providing the services after school hours: (Circle all that apply)

| | |
|---|---|
| Access to services | Minimize disruption of school attendance |
| Reduce school refusal behavior | Reduction of distractions |
| Developmental reasons i.e. fatigue | Medicinal support in tact |
| Transference of skills | Modeling boundaries |
| Transportation barriers | Other: |

*For students receiving therapy services at schools; parents/guardians should plan to schedule a care conference every 6-8 weeks to update therapist on progress and goals. Signing this form does not guarantee that your child will be seen at school, this depends on available confidential space at the school, your child's class schedule and provider schedules. GCMAC will bill sessions to your child's insurance company. Signed form is valid for one year from signature date unless revoked by parent/guardian.*

## PARENT INVOLVEMENT IN BEHAVIORAL HEALTH INTERVENTION SERVICES (BHIS) AGREEMENT

I, _____, understand that by allowing my child's involvement in Behavioral Health Intervention Services (BHIS) through the Grace C Mae Advocate Center, I will be required to participate in family sessions on a regular basis (at least one time monthly and at most once a week as determined by my child's BHIS counselor). By signing this agreement, I acknowledge that my participation in these sessions will be mandatory in order for my child to continue to receive BHIS services. Signed form is valid for one year unless otherwise specified.

Parent/Guardian Signature: Date:

School Staff Signature: Date:

GCMAC Staff Signature: Date:

***Signing this form does not guarantee that my child will receive services at school- this is dependent on school space and provider availability.***

Grace C. Mae Advocate Center
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www.gracecmae.org
Revised 7/18/23

Client Name: DOB: Medicaid ID#

## AUTHORIZATION TO OBTAIN, DISCLOSE AND EXCHANGE PROTECTED HEALTH INFORMATION

**AUTHORIZATION**-The undersigned hereby authorizes the name/agency listed to Obtain From, Disclose To, and Exchange with, protected health information either orally or in writing to Grace C Mae Advocate Center, Inc.

**Primary Care Physician**_____

**Clinic location: City**: _____ **Phone**: _____

A. Any and all information, EXCEPT substance abuse (drugs and alcohol), mental health, and AIDS-related information, must be specifically authorized in Section E to be disclosed: OR ONLY the following information (check only if applicable)
Check one(s) that applies:

☐ Summaries and notes of participation in treatment
☐ Psychological and psychiatric testing & evaluation results
☐ Information relating to medical history
☐ Evaluations and Recommendations
☐ Treatment Plan, Progress & Discharge reports
☐ Information relating to social history

Other information: Care Coordination and medical updates_____

B. PURPOSE-The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

C. SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PROTECTED BY STATE AND FEDERAL LAW
I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and AIDS.

☐ Substance abuse (drug or alcohol) information
☒ Mental Health information
☐AIDS-related information

D. Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in the authorization. The undersigned has a right to inspect the disclosed information and information being obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months (or_____months) from the date it is signed, or if applicable, until the date of the final disposition of the conditional release or other court action in connection with which this consent is given {42 CFR 2.35 J(c)}. Also, the undersigned understands he/she may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon, and by giving written notice to Grace C Mae Advocate Center, Inc.

E. I hereby authorize disclosure of protected health information as indicated above and acknowledge that I may receive a copy of this document upon request.

_____ _____ _____

Client/Parent/ Legal Guardian Signature Date Relationship to Client

_____ _____

Witness Signature Date

**I understand that initialing here: _____ constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.**

Grace C. Mae Advocate Center
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## AUTHORIZATION TO OBTAIN, DISCLOSE AND EXCHANGE PROTECTED HEALTH INFORMATION

**AUTHORIZATION**-The undersigned hereby authorizes the name/agency listed to Obtain From, Disclose To, and Exchange with, protected health information either orally or in writing to Grace C Mae Advocate Center, Inc.

**Emergency Contact** _____ **Relationship**_____

**Address** _____ **Phone:** _____

A. Any and all information, EXCEPT substance abuse (drugs and alcohol), mental health, and AIDS-related information, must be specifically authorized in Section E to be disclosed: OR ONLY the following information (check only if applicable)
Check one(s) that applies:

☐ Summaries and notes of participation in treatment
☐ Evaluations and Recommendations
☐ Psychological and psychiatric testing & evaluation results
☐ Treatment Plan, Progress & Discharge reports
☐ Information relating to medical history
☐ Information relating to social history

Other information: Care coordination and Emergency situation information_____

B. PURPOSE-The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

C. SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PROTECTED BY STATE AND FEDERAL LAW
I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and AIDS.

☐ Substance abuse (drug or alcohol) information
☒ Mental Health information
☐AIDS-related information

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E. I hereby authorize disclosure of protected health information as indicated above and acknowledge that I may receive a copy of this document upon request.

_____ _____ _____

Client/Parent/ Legal Guardian Signature | Date | Relationship to Client

_____ _____

Witness Signature | Date

**I understand that initialing here: _____ constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.**

Client Name: DOB: Medicaid ID#

## AUTHORIZATION TO OBTAIN, DISCLOSE AND EXCHANGE PROTECTED HEALTH INFORMATION

**AUTHORIZATION**-The undersigned hereby authorizes the name/agency listed to Obtain From, Disclose To, and Exchange with, protected health information either orally or in writing to Grace C Mae Advocate Center, Inc.

**School District** _____ **Grade**_____ **Teacher/counselor** _____

**Address** _____ **Phone:** _____

A. Any and all information, EXCEPT substance abuse (drugs and alcohol), mental health, and AIDS-related information, must be specifically authorized in Section E to be disclosed: OR ONLY the following information (check only if applicable)
Check one(s) that applies:

☐ Summaries and notes of participation in treatment
☐ Psychological and psychiatric testing & evaluation results
☐ Information relating to medical history
☐ Evaluations and Recommendations
☐ Treatment Plan, Progress & Discharge reports
☐ Information relating to social history

Other information Coordination of treatment, faxing appointment attendance per parent/guardian request, _____

B. PURPOSE-The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

C. SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PROTECTED BY STATE AND FEDERAL LAW
I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and AIDS.

☐ Substance abuse (drug or alcohol) information
☒ Mental Health information
☐AIDS-related information

D. Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in the authorization. The undersigned has a right to inspect the disclosed information and information being obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months (or_____months) from the date it is signed, or if applicable, until the date of the final disposition of the conditional release or other court action in connection with which this consent is given {42 CFR 2.35 J(c)}. Also, the undersigned understands he/she may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon, and by giving written notice to Grace C Mae Advocate Center, Inc.

E. I hereby authorize disclosure of protected health information as indicated above and acknowledge that I may receive a copy of this document upon request.

_____ _____ _____

Client/Parent/ Legal Guardian Signature | Date | Relationship to Client

_____ _____

Witness Signature | Date

**I understand that initialing here: _____ constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.**

Client Name: DOB: Medicaid ID#

## AUTHORIZATION TO OBTAIN, DISCLOSE AND EXCHANGE PROTECTED HEALTH INFORMATION

**AUTHORIZATION**-The undersigned hereby authorizes the name/agency listed to Obtain From, Disclose To, and Exchange with, protected health information either orally or in writing to Grace C Mae Advocate Center, Inc.

**Name/Agency**_____

**Address** _____ **Phone:** _____

A. Any and all information, EXCEPT substance abuse (drugs and alcohol), mental health, and AIDS-related information, must be specifically authorized in Section E to be disclosed: OR ONLY the following information (check only if applicable)
Check one(s) that applies:
☐ Summaries and notes of participation in treatment ☐ Evaluations and Recommendations
☐ Psychological and psychiatric testing & evaluation results ☐ Treatment Plan, Progress & Discharge reports
☐ Information relating to medical history ☐ Information relating to social history
Other information:_____

B. PURPOSE-The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

C. SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PROTECTED BY STATE AND FEDERAL LAW
I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and AIDS.
☐ Substance abuse (drug or alcohol) information
☒ Mental Health information
☐AIDS-related information

D. Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in the authorization. The undersigned has a right to inspect the disclosed information and information being obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months (or_____months) from the date it is signed, or if applicable, until the date of the final disposition of the conditional release or other court action in connection with which this consent is given {42 CFR 2.35 J(c)}. Also, the undersigned understands he/she may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon, and by giving written notice to Grace C Mae Advocate Center, Inc.

E. I hereby authorize disclosure of protected health information as indicated above and acknowledge that I may receive a copy of this document upon request.

_____ _____ _____

Client/Parent/ Legal Guardian Signature Date Relationship to Client

_____ _____

Witness Signature Date

**I understand that initialing here: _____ constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.**