https://faiththerapeutics.org

Phone: 337-362-1956

Fax: 337-270-3399

Email: FaithTherapeutics@faiththerapeutics.org

Parents, Guardians, Patients:

Id personally like to extend a warm heartfelt, Welcome from everyone at Faith Therapeutics and thank you for choosing us to be part of your family's journey. We are honored that you have entrusted us with your child's care and growth through Applied Behavior Analysis (ABA) services.

ABA is a proven, evidence-based approach to improving socially significant behaviors and fostering meaningful, lasting progress. Our team is committed to delivering compassionate, individualized care that respects your family's goals, values, and needs.

As partners in this journey, you can expect:

- A customized treatment plan tailored to your child's strengths and challenges
- Ongoing support and collaboration with your family
- Clear communication, data-driven progress updates, and professional integrity
- A safe, respectful, and nurturing therapeutic environment

We look forward to working closely with you and celebrating every step forward, big or small. Your involvement is key to your child's success, and we encourage you to stay engaged, ask questions, and share your observations and goals with us.

If you have any questions or need additional support as we begin this process, please don't hesitate to reach out. We are here for you every step of the way.

With gratitude, Raylynn Carlson

Raylynn Carlson MA, BCBA, LBA, COO

Faith Therapeutics

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Notice of information requirements

In order for us to process authorization for ABA services with your insurance company, Faith Therapeutics, we will need the following:

- Assessment Report from the doctor who diagnosed your child with their presenting disorder (Autism, ADHD, developmental delay etc). This document is usually several pages in length and includes the name and results of the assessment(s) used to diagnose the disorder. These reports are often call comprehensive diagnostic evaluations. **Can be faxed directly from diagnosing physician 337-
- Referral letter and/or Prescription for ABA services from either your child's diagnosing physician or current primary care physician (usually from diagnosing physician). This letter must be on your doctor's letterhead and include the doctor's signature. The letter should be dated within the last 90 days and include the patient's name, date of birth, diagnosis, and the wording "refer to Faith Therapeutics for ABA Therapy". **Can be faxed directly from referring physician to Faith Therapeutics at 337-270-3399.
- Authorization to release or obtain healthcare information from provided by Faith Therapeutics. Please fill out this form using the diagnosing physician's information. This allows Faith Therapeutics to contact the patient's diagnosing physician in order to obtain any supplemental medical information that may be needed throughout the insurance authorization process as well throughout the course of therapy.
- Individualized Education Plan (if applicable).
- "Enrollment Packet" paperwork provided by Faith Therapeutics.
- Copies or pictures of Parent(s) or Guardian(s) driver's licenses and insurance cards (front and back).

We will make copies of any original documents. If there is anything we can do to assist you in this process, please do not hesitate to call our office at 337-362-1956 or Email at FaithTherapeutics@faiththerapeutics.org. Delaying providing these records and or documents will impact admission into the Applied Behavior Analysis program.

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PATIENT ENROLLMENT

Patient			
Last Name:	First Name:	MI:	D.O.B.:
Age:	Primary Language:	Gender:	Ethnicity:
Religion:		SSN:	
Mailing Address:			
(Street or PO Box)	(City)	(State)	(Zip Code)

Legal Guardian			
Last Name:	First Name:	MI:	D.O.B.:
Relationship to Patient:		SSN:	Ethnicity:
Mailing address is the same as the Patient		Yes	NO
Mailing Address:			
(Street or PO Box)	(City)	(State)	(Zip Code)
Phone Number:		Email address:	
Employer:		Work Phone Number:	

Emergency Contact			
Last Name:	First Name:	MI:	D.O.B.:
Relationship to Patient:		SSN:	Ethnicity:
Resides in the home with the patient?		Yes	No
Mailing Address:			
(Street or PO Box)	(City)	(State)	(Zip Code)
Phone Number:		Email address:	
Employer:		Work Phone Number:	

Emergency Contact			
Last Name:	First Name:	MI:	D.O.B.:
Relationship to Patient:		SSN:	Ethnicity:
Resides in the home with the patient?		Yes	No
Mailing Address:			
(Street or PO Box)	(City)	(State)	(Zip Code)
Phone Number:		Email address:	
Employer:		Work Phone Number:	

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Primary Insurance

Policy Holder's Name:	
Holder's Birth Date:	Policy Holder's SSN:
Insurance Carrier:	ID Number:

Secondary Insurance

Policy Holder's Name:	
Holder's Birth Date:	Policy Holder's SSN:
Insurance Carrier:	ID Number:

Insurance Policy

1. All insurance recipients must present their current insurance card at the time of initial service. If you do not have your insurance card, you will be considered a self-pay patient.

2. If you have insurance that is primary with Medicaid as secondary, you must provide this information at the time of service. If you fail to disclose your primary insurance, your claim will be denied.

3. Patient/Guarantor will be responsible for all charges incurred if no insurance card is presented or if any amount not paid or covered by their insurance. Services not covered by your insurance company will be due at the time of service. It is your responsibility to know what is covered and what is not.

4. You must immediately notify our office if there are any changes in your insurance coverage or change of insurance of carriers.

This is to certify that I (we) the undersigned, voluntarily consent to the administration of the practice of diagnostic procedure/imaging/photography and therapy treatment by providers, authorized agents and employees of the practice as may, in their professional judgment be deemed necessary or beneficial. Unless otherwise specified, all healthcare providers may obtain additional consents for individual procedures. I (we) acknowledge that no guarantees have been made to me (us) as to the effect of such examination or treatment. I understand that the insurance benefits are provided directly for the patient/guarantor and I, the undersigned, further agree and understand that I am directly responsible for all financial obligations to Faith Therapeutics and associates. If for any reason I fail to meet my financial obligations to Faith Therapeutics and associates, to seek a collection agency or court action as a means of collection, I understand that I will be responsible for the balance due on my collections plus all fees related to the collection including legal representation. I the undersigned fully understand and have read the insurance policy.

Printed name of legal representative	Date
Signature of legal representative	Date
Faith Therapeutics office use only	If submitting electronically, your typed full name above serves as signature.
Witness	Date

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Consent To Use or Disclose Information for Treatment, Payment or Health Care Operations

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information") by Faith Therapeutics in order to carry out treatment, payment, or health care operations. I understand that I should review Faith Therapeutics Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and I have the right to review such notice prior to signing this consent form. Faith Therapeutics reserves for itself the right to change the term of its notice of privacy practices for protected health information at any time. If Faith Therapeutics does change the terms of notice of practices for protected health information, I may obtain a copy of the revised notice by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Faith Therapeutics is not required to agree to such requested restriction(s); however, if Faith Therapeutics does agree to my requested restriction(s), such restriction(s) are then binding on Faith Therapeutics.

At all times, I retain the right to revoke this consent in writing, to Faith Therapeutics. Except to the extent that action has already been taken. Faith Therapeutics may refuse to treat Patient if he/she (or authorized representative) does not sign this Consent Form (except to the extent Faith Therapeutics is required by law to treat Individuals). I authorize payment of medical benefits to the undersigning physician or supplier for services provided. I authorize the release of any medical or other information necessary to process a claim. I also give my authorization to request payment of government benefits for the party who accepts assignment.

If patient (or authorized representative) signs this consent form and then revokes consent, Faith Therapeutics has the right to refuse to provide further treatment to patient as of the time of revocation (except to the extent that Faith Therapeutics is required by law to treat individuals).

I, the undersigned, further agree and understand the notice of consent to use or disclose information for treatment, payment, or health care operations.

Printed name of legal representative	Date
Signature of legal representative	Date
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Notice of Privacy Policy

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or verbally, are kept properly confidential. This Act gives you, the client, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse Protected Health Information (PHI).

Uses and Disclosures of Protected Health Information

Your protected Health Information may be used and disclosed by your BCBA, your therapist, and/or our office staff for the purpose of providing quality health care services to you, to pay your health care bills, to support operation of the therapy practice and any other use required by law. Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law.

Authorization

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following.

- All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
- All records from consultations and/or evaluations, test scores, and as progress notes.
- All disability, Medicaid or Medicare records including claim forms, if applicable.
- All billing records include all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the entire period from consultation, start of treatment to last therapy session.

This protected health information may be disclosed for insurance coverage verification and medical billing purposes.

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Notice of Privacy Policy

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Page 2 of 2.

By signing below, you acknowledge that you have read the attached notice of privacy policy and understand that you are to maintain confidentiality of all past, present, and future clients, families, and staff at all times. Further, you consent to the release of your protected health information as outlined in the above policy. I, the undersigned, further agree and understand the notice of privacy policy.

Printed name of legal representative	Date
Signature of legal representative	Date
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Consent for Client Services and Assessment

I understand the following statements to remain active throughout all treatments, assessments, or other services provided by Faith Therapeutics and associates. Faith Therapeutics and associates operate on the premise of incorporation of current evidence-based learning and behavioral training procedures in their programs. Faith Therapeutics and associates emphasizes the fact that children are treated individually and respond differently to training programs. Faith Therapeutics and associates does not make any predicative claims about the outcome of my child's program and success of levels of advancement. Faith Therapeutics and associates retains sole property right over all original documents generated for my child's intervention. Any information concerning my child's involvement and intervention will not be released or shared unless the Faith Therapeutics and associates is ordered to do so by the courts, deems in necessary for an individual's safety, or is given my expressed written consent. I understand the following statements regarding clinical oversight to remain active throughout all treatments, assessments, or other services provided by Faith Therapeutics and associates. I understand that all staff members are supervised by a Board-Certified Behavior Analyst who may not be on site during sessions. Faith Therapeutics and associates may employee various individuals that have been trained to carry out my child's specific behavior plan and deliver training procedures. I understand that I have the right to be informed of all training procedures used with my child. I understand and approve that Faith Therapeutics and associates may use the following assessments: Direct Observation, Review of Records, Notes, Conversations, Photographs, Assessment Reports, Interviews, Data, Videos, Intervention/Treatment/Educational Plans, ABLLS-R, VB-MAPP, and additional assessments as necessary. I understand I have the right to be informed about assessments used. I understand I have the right to be informed about assessments used. I understand that I have the right to remove my child from the training program at any time. I understand that Faith Therapeutics and associates may recommend termination of participation in the program if at any time clinical opinion deems it not to be beneficial.
I give my consent to my child to participate in a behavioral intervention at Faith Therapeutics and associates This consent is valid until withdrawn or amended. Consent may be withdrawn at any time for any reason by submitting a request in writing to a representative of Faith Therapeutics and associates.
I, the undersigned, further agree and understand the notice consent for client services and assessment.

Printed name of legal representative	Date
Signature of legal representative	Date
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Declaration of Professionalism of Behavior Analysts for Prospective Patient /patient's Family

This document is designed to inform you about the background of the board-certified behavior analyst working with your child and to ensure that you understand the requirements of professional relationships. Page 1 of 2

Faith Therapeutics employees Board Certified Behavior Analysts (BCBA) who have been involved with the treatment of developmental disabilities since 2012. All Louisiana based Behavior Analyst are required to obtain a Master's degree or higher from an accredited university, complete field specific coursework, complete up to 2,000 hour of supervised field work, pass national certification, pass a criminal background check, and obtain licensure from the state of Louisiana. For more information about the board that regulates these licensures, code of ethics, and more visit https://www.bacb.com/bcba.

Behavior analysis is a unique method of treatment based on the fundamental assumption that the most important human behavior is learned over time and that it is currently maintained by consequences in the environment. A behavior analyst's profession is to work with specified behaviors you would like to change. Both increases in positive behavior and decreases in problematic behaviors can be achieved with behavior modification. With family input determination what behaviors require modification for increase or decrease and creating significant social changes based on the child's needs is possible. From a professional standpoint, behavioral analysts do not make judgments about behavior. Behavior is understood as an adaptive response (a way of coping with a situation). Behavior analyst support adjusting and modifying behaviors to reduce pain, increase self-sufficiency, and improve quality of life for all patients. One of the most unique aspects of behavior analysis as a form of treatment is that decisions are made based on objective data that are collected on a regular basis. Please know that it is impossible to guarantee any specific results regarding your child's goals as all patients' progress is different.

Guardian input is essential for generalization of skills. The Behavior Analyst assigned to your case will consult at each step in the process. The guardians will be given opportunities to communicate their goals; have assessments, results, and progress monitoring explained in understandable terms. Guardians of special needs children are encouraged to be as active in their child's life, and treatment, as possible. Guardians are expected to attend regular meetings with the Behavior Analyst. Your Behavior Analyst will help you and your child navigate. Prior to the start of services, the Behavior Analyst will design an intervention or treatment plan and ask for approval of that plan. Viewing of live sessions or onsite training with patients is available to the guardian or other approved individuals.

Board Certified Behavior Analysts activities are regulated by a code of ethics that is provided by the regulatory board. Within this code the interactions between Behavior Analyst and patients/ Guardians are defined to avoid conflicts and avoid harm. Behavior Analyst are not allowed to collaborate with you in any other capacity except as your behavior therapist or consultant. It is not appropriate to ask staff to babysit, transport, or perform any other non-therapy-based tasks. According to the professional code of ethics, it is not appropriate for staff to accept gifts. It is expected that you will read the client handbook and adhere to all of the regulations of services that the center has created. This includes arriving at sessions in a timely manner, informing them of medications or health conditions, confidential agreements, and/or cancellation policies.

It is assured to you that all services will be rendered in a professional and ethical manner consistent with accepted ethical standards. A copy of these Guidelines is available upon request.

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Declaration of Professionalism of Behavior Analysts for Prospective Client/Client's Family

This document is designed to inform you about the background of the board-certified behavior analyst working with your child and to ensure that you understand the requirements of professional relationships. Page 1 of 2

Board Certified Behavior Analysts activities are regulated by a code of ethics that is provided by the regulatory board. Within this code the interactions between Behavior Analyst and patients/ Guardians are defined to avoid conflicts and avoid harm. Behavior Analyst are not allowed to collaborate with you in any other capacity except as your behavior therapist or consultant. It is not appropriate to ask staff to babysit, transport, or perform any other non-therapy-based tasks. According to the professional code of ethics, it is not appropriate for staff to accept gifts. It is expected that you will read the client handbook and adhere to all of the regulations of services that the center has created. This includes arriving at sessions in a timely manner, informing them of medications or health conditions, confidential agreements, and/or cancellation policies. It is assured to you that all services will be rendered in a professional and ethical manner consistent with accepted ethical standards. A copy of these Guidelines is available upon request.

Clients and their therapists have a confidential and privileged relationship. Anything that is observed, discussed or related to clients is withheld. In addition, the information that is recorded in your file is limit to protect your privacy. You should be aware that confidentiality has limitations as stipulated by law including the following:

- I have your written consent to release information.
- I determine that the client is a danger to themselves or others.
- I have reasonable grounds to suspect abuse or neglect of a child, disabled adult, or an elder adult.
- I am ordered by a judge to disclose information.

If at any point you or your behavior analyst seeks to terminate the professional relationship outlined above, either party may do so. I, the undersigned, further agree and understand notice of declaration of professionalism of behavior analysts for prospective client/client's family.

Printed name of legal representative Date

Signature of legal representative Date

Faith Therapeutics office use only If submitting electronically, your typed full name above serves as signature.

Raylynn Carlson MA BCBA LBA

Raylynn Carlson MA, BCBA, LBA Date

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Authorization to Treat Minor

I, the undersigned, am the legal parent or guardian of the above-named minor. I have disclosed applicable restrictions based on legally binding child custody arrangements. Including restrictions of access to information regarding treatment as well as physical custody. It is my responsibility to disclose legal custody changes at the time at which they occur. I will provide Faith Therapeutics with copies of any relevant documents in regard to legal guardianship. I hereby authorize the following individual(s) to act on my behalf in providing therapy decisions that are in the best interest of my child. In addition, the listed individuals are authorized to pick up/ drop off my child from therapy sessions. It is my responsibility to update this list as necessary. I understand that each person listed will be required to produce identification and that the provided identification will be placed in the student's file. This authorization will remain active, unless a written statement is received by the parent/guardian to revoke an authorized person. I, the undersigned, further agree and understand notice of authorization to treat minors.

Name: Relationship to patient:

Cell Phone Number: Email:

Name: Relationship to patient:

Cell Phone Number: Email:

Name: Relationship to patient:

Cell Phone Number: Email:

Name: Relationship to patient:

Cell Phone Number: Email:

Printed name of legal representative Date

Signature of legal representative Date

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Witness Date

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Therapy Records Release Policy

A therapy records release must be filled out by the parent or legal guardian of the patient prior to the copying of any therapy records. Please request or fill out one release per patient.

- All therapy records 12 pages or more will be copied for our personal use for a fee of $15.00 per patient.
- Therapy records of less than 12 pages will be copied for your personal use one (1) time free of charge.
- All additional requests will have a $15.00 charge. Please allow 10 business days for this to be completed.

If you are transferring to another therapy provider, you may complete a therapy records request for your child's records to be forwarded to your new provider at no charge to you. Please allow 30 business days for this transfer to be completed.

In order to provide the highest quality of care, Faith Therapeutics encourages guardians of our patients to facilitate the coordination of care with medical, educational, or other behavioral health providers including Speech Therapist, Occupational Therapist, Special Education Teachers, Primary Care Physician (PCP), Neurologist, or Psychologist. Guardians may request the required paperwork that allows Faith Therapeutics to reach out to these other providers to coordinate care. Faith Therapeutics will also provide reports lor PCP or referring providers upon request at no charge. I, the undersigned, further agree and understand the notice of the therapy records release policy.

Printed name of legal representative	Date
Signature of legal representative	Date
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Authorization To Release Information	
Patient Name:	DOB:
Treatment Dates/Information to be Released:	
Specific Information is needed for:	

Release to	**Release From**
Entity or person's name:	Faith Therapeutics
Address:	Address:
Phone number:	Phone number: 337-362-1956
Fax:	Fax: 337-270-3399

Please state how you would like information released

Mail (provided address above) ◯ Fax Number (provided number above) ◯ Pickup ◯

I authorize the release of portions of the record relating to substance abuse, psychological/psychiatric conditions and/or communicable disease, including AIDS, if present.

I understand that this consent is revocable except to the extent that action has already been taken. This consent wil automatically expire 90 days from the date of signature, unless another date is specified below.

Note: Unless otherwise permitted by law, further release of this information is prohibited without prior written consent

Printed name of legal representative	Date
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Request for the Release of Client Information

I authorize Faith therapeutics to the release medical records as stated above to the following representatives of defendants/insurance carriers in the above-entitled matter who have agreed to pay reasonable charges made by you:

Name of Representative or Company:

Representative Capacity (e.g. attorney, insurance company, school, etc.):

Phone Number:

Fax:

Street Address:

City, State and Zip Code:

Items to be released:

I understand the following: See CFR §164.508(c)(2) (i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties for billing purposes or court cases if needed.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect from date signed and until treatment ends at Faith Therapeutics or at time you may choose to revoke this authorization.

Printed name of legal representative Date

Signature of legal representative Date

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Witness Date

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Miscellaneous Consents

For the safety and security of all patients, visitors, and staff Faith therapeutics facilities are equipped with video recording systems. Video surveillance is used solely to enhance the safety, security, and operations of this facility. These recordings may be reviewed by authorized personnel only and handled in accordance with applicable privacy laws and regulations (e.g., HIPAA where applicable)..If you have any concerns or questions, please contact the facility administrator.

Picture and Video Release: I give permission to the staff and agents of Faith Therapeutics to video tape and/or take pictures of me/my child for training purposes and to share with me. I also understand that these pictures/videos will be immediately deleted once the parent/guardian has viewed them.	☐ Yes ☐ No
Holiday Celebrations: I understand and acknowledge that Faith Therapeutics may include celebratory activities surrounding traditional U.S. Holidays including New Years, Valentine's Day, Mardi Gras, St. Patrick's Day, Easter, Independence Day, Memorial Day, Halloween, Thanksgiving, and Christmas, and birthdays. My child may participate in these celebrations.	☐ Yes ☐ No

If you would like to have any of these holidays excluded, please list them:

If you would like to include any non-traditional holidays, please list them.:

Toileting/ Hygiene disclosure: I understand that Faith Therapeutics employs both male and female therapist who may be performing toileting routines as needed. I consent that staff members can escort my child to the restroom and aid in the full process of toileting as needed. I also understand that by making exclusions, it may be difficult for Faith Therapeutics to assist in toilet training due to staff constraints and availability.	☐ Yes ☐ No

If you would like to list any exclusions, please list them:

.

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Patient Bill of Rights

Faith Therapeutics recognizes and respects the rights of patients and their families and treats them with courtesy and dignity. Our facility provides care that preserves cultural, psychosocial, spiritual, and personal values, beliefs, and preferences. We encourage families to become active partners in care by asking questions, seeking resources, and advocating for the services and support they need.

You Have the Right too.

Receive care that is free from discrimination. This means that you should not be treated differently because of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. Get valuable information about your care. In your preferred language. In a way that meets your individual needs related to vision, speech, hearing, or cognition. About your diagnosis, treatment plan, benefits, risks and side effects, likelihood of reaching your goals, options, and expected/ unexpected outcomes. Make decisions about care. This is called informed consent. At times, we are required, by law and regulation, to disclose or report certain information without your consent. Informed consent also applies to taking pictures, videos, or other images, and recordings of you for purposes other than your care.

Should you occur a problem.

Faith Therapeutics is committed to resolving all disputes at the local level. You may address all complaints to Raylynn Pommier Faith Therapeutics Owner Via Email: FaithTherapeutics@faiththerapeutics.org Phone
If you are unable to resolve your dispute at the local level, you may contact the Department of Health and Hospitals on the phone: 1-800-660-0488, Mailing Address: Louisiana Department of Health P.O. Box 629 Baton Rouge, LA 70821-0629. I, the undersigned, further agree and understand notice of patient bill of rights.

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Notice of Records Requirements

Guardians must provide the following records and documentation to Faith Therapeutics upon enrollment request.

- Guardian identification.
- Client insurance card.
- Referral from primary care physician.
- Copy of the most recent wellness visit from primary care physician.
- Comprehensive Diagnostic Evaluation.
- Individualized Education Plan (if applicable).
- Speech-Language Pathology report and progress report (if applicable).
- Occupational Therapy report and or progress report (if applicable).
- Physical Therapy report and progress report (if applicable).
- Any other treatment reports available (if applicable).

Guardians should be aware that these documents / records are required in the interest of collaboration with other service providers and supportive of best practices for treatment. In addition, records review meets standards by the Louisiana Department of Health in order to conduct Applied Behavior Analysis services. Delaying providing these records and or documents will impact admission into the Applied Behavior Analysis program. I, the undersigned, further agree and understand notice of records requirements.

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Patient Handbook Acknowledgment

I, the undersigned, am the legal parent or guardian of the above-named minor agree with the following statements. It is the guardian's responsibility to access the handbook, review all policies, and voice concerns. Guardians are expected to abide by all polices set forth by Faith therapeutics within the patient handbook.

- I have been provided with a copy of the patient handbook.
- I am aware that the handbook is available to me online at https://faiththerapeutics.org at all times.
- I am aware I may access the handbook on site at my request at all times.

By signing below the I, the undersigned, further agree and understand of patient handbook.

Printed name of legal representative	Date
Signature of legal representative	Date
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Email: FaithTherapeutics@faiththerapeutics.org

Late absentee policy Acknowledgment

I, the undersigned, am the legal parent or guardian of the above-named minor agree with the following statements. It is the guardian's responsibility to access the late policy that is located in the patient handbook. Guardians are expected to abide by the late absentee policy. Faith Therapeutics has a sincere desire to provide the best and most effective care for your child. Repeated tardiness or absences to scheduled appointments are unacceptable due to the one-to-one nature of applied behavior analysis. Emergency situations are exceptions to the policy. If your child has to be absent a doctor's note or one-week prior notice is required. If your child must be late or absent, please give notice as soon as it is. You may call the office at 337-362-1956. The answering machine is checked regularly during non-business hours. You may also email at FaithTherapeutics@faiththerapeutics.org. If you cannot keep the hours that you have previously agreed to or need to adjust scheduled times, please let us know so we can examine the schedule together and come to a resolution. Together we can help your child receive the best therapy possible. All instances' absences or late arrivals are documented. We understand that sometimes things cannot be predicted, we only ask that when something arises, you notify our office ASAP so we can make the appropriate adjustments. If you miss 3 appointments without calling 24 hrs. Prior to the appointment you may be released from therapy and placed on the waiting list. This is not intended to cause any inconvenience to you, but to make these appointments available to patients who need ABA therapy. If you are late to your scheduled appointment, you must notify the office as soon as possible. If you do not notify the office, all therapy for that day may be cancelled.

- I have been provided with a copy of the late absentee policy.
- I am aware that the late absentee policy is available to me online at https://faiththerapeutics.org/ at all times.
- I am aware I may access the late absentee policy on site at my request at all times.

By signing below the I, the undersigned, I further agree and understand late absentee policy.

Printed name of legal representative	Date
Signature of legal representative	Date
Faith Therapeutics office use only	If submitting electronically, your typed full name above serves as signature.
Witness	Date