Child Name (first, last): _____

Parent/Guardian Name: _____ Date Signed: _____

SANTOSHA
WELLNESS

Phone 269-254-8130 | Fax 866-376-0467
www.santoshawellnesskzoo.com

Please read all the following information carefully and sign/initial where indicated.

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Santosha Wellness, LLC. In addition, I hereby consent to the disclosure of my child's personal health information for the purposes of treatment, payment, and health care operations only, unless I provide written consent. I also understand that by signing this, I acknowledge that Santosha Wellness, LLC works as a healthcare team, and therefore my child's health information may be shared among team members only as it is pertinent to their care and treatment.

Signature: _____ Date: _____

I am aware of my child's needs and agree to allow him/her to receive treatment at Santosha Wellness, LLC. I permit its employees to treat him/her in ways they judge are beneficial to him/her. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

Signature: _____ Date: _____

I acknowledge that all information I have provided about my child is accurate and true.

Signature: _____ Date: _____

Payment Guarantee

I agree to pay Santosha Wellness, LLC for the services provided to my child. If any law, such as workers' compensation or insurance contract prohibits payment for the these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my child's treatment unless agreed to in writing by myself and a representative of Santosha Wellness, LLC.

Signature: _____ Date: _____

Financial Policy

You are responsible for all your insurance deductibles, co-payments, co-insurances, and supplies at the time of service.

Our staff verifies your insurance benefits prior to the onset of services as a courtesy to you (Occupational Therapy, Speech Therapy, Art Therapy services only). Although we strive to obtain the most accurate information possible, the quoted benefits from your insurance company are not a guarantee of payment. Should you need detailed information about your coverage, please contact your insurance company directly.

In the event we receive a denial from your insurance company, or if you are paying out-of-pocket (not billing to an insurance company and instead being billed as a fee-for-service), and you choose to continue with therapy, payment is due at the time of service unless otherwise arranged with Santosha Wellness, LLC. Please speak with office staff for a printout of our fee schedule.

You are financially responsible for payment of services rendered. Santosha Wellness, LLC will work with you as best they can, however if you become delinquent on your account for more than 30 days and are not actively paying towards the balance, you will be removed from the schedule and sent to collections.

There will be a $25 service charge for all returned/bounced checks.

I hereby authorize payment be made directly to Santosha Wellness, LLC.

Signature: _____ Date: _____

Closure, Cancellation, and No-Show Policy

If inclement weather or other unanticipated event warrants the closure of Santosha Wellness, LLC, all scheduled clients will be notified via phone, text message, and/or email as well as all social media accounts (ie. Facebook) no later than 7:00am of that business day.

If Kalamazoo Public Schools are closed due to inclement weather such as a Snow Day, Santosha Wellness will also be closed. In this event, each individual family will not be notified; they instead are expected to be aware of this policy and can see updates on our social media accounts for closures.

Santosha Wellness, LLC will be closed for the following major holidays:
Memorial Day, Fourth of July, Labor Day, Thanksgiving and the day after, and December 24-January 1 in observance of the holidays.

Occupational Therapy, Speech Therapy, and Art Therapy Clients Only
If you must cancel your scheduled appointment for any reason, you must cancel at least 24 hours in advance or you will be subject to a $25 late cancellation fee that will be due at your next visit. After 3 cancellations of less than 24 hours notice, you may be subject to removal from the schedule at the discretion of the office staff and therapeutic team.

If you no-show for your scheduled appointment without calling ahead of time, you will be subject to a $35 no-show fee that will be due at your next visit. After 2 no-shows, you may be subject to removal from the schedule at the discretion of the office staff and therapeutic team.

Signature: _____ Date: _____

Waiver Form

I, _____, the parent/guardian of _____ (thereafter referred to as "my child") give permission for my child to participate in Santosha Wellness, LLC programs and Services.

I hereby release Santosha Wellness, LLC principal owners, therapists, employees, and representatives and all other individuals or organizations acting on behalf of Santosha Wellness, LLC from any and all claims which I or my child may have, resulting from or in connection with my child's participation in Santosha Wellness, LLC programs. This includes, but without limitation, any claim, demands or causes of action for injuries to my child, including but not limited to injuries resulting from the use of play/therapy equipment during the program at Santosha Wellness, LLC or sponsored by Santosha Wellness, LLC in the community.

I understand that I should be present at all times during delivery or service to my child. If I choose not to, I understand that the aforementioned statements still apply in my presence or absence during the services provided. This agreement is signed for the purpose of fully and completely releasing, discharging, and indemnifying Santosha Wellness, LLC in connection with their programs from all liability as herein described.

Signature: _____ Date: _____
Parent/Guardian

Reciprocal Consent for Release of Confidential Information for Treatment

I, _____, date of birth _____, hereby authorize the following people/organizations to release information in my client/child's records to one another in order to best coordinate care. I acknowledge that I am the legal guardian/parent of my child, _____, date of birth _____.

Information may be released only under the following conditions:

Name of person(s) or organization(s) between whom disclosure is to be made:

Name: _____

Organization: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Name: _____

Organization: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Name: _____

Organization: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Name: _____

Organization: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Specific type of information to be released: _____

Purpose of disclosure: _____

Limitations or information not to be shared: _____

I understand what information is to be released and the intended use of that information. I am aware that this consent can be revoked in writing at any time. My signature also indicates that I have read this form and/or have had it read to me and explained in language that I understand. All blank spaces have been filled in except for signature and dates. I also understand that treatment cannot be denied or withheld for refusing to authorize a release of information.

This consent form expires at the termination of treatment, unless otherwise specified or at the verbal or written revocation of this consent for release of confidential information.

Signature: _____ Date: _____