

Child Name (first, last): _____

Parent/Guardian Name: _____ Date Signed: _____



SANTOSHA
W E L L N E S S

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.

Santosha Wellness, LLC will contact your insurance carrier for benefit review and provide you with a Benefit Verification form as a professional courtesy. This 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 understand that it is ultimately my responsibility to understand my benefits and how they apply to 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.

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 or have not paid off your balance in full within 3 months, you will be removed from the schedule and are subject to being 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: _____

If you'd like your card to remain on file and be charged at each visit, please provide us with your card information. By providing us with the information and signing below, you acknowledge that you are providing us with permission to run your card for payment of co-pay, co-insurance, and/or balances due at each appointment.

Card Number _____ Expiration Date: (mm/yyyy) _____

CVC Code (back of card): _____ Name on Card: _____

Signature: _____ Date: _____

Closure, Cancellation, and No-Show Policy

Inclement Weather

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.

School Closures

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.

Holidays

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.

Late Cancellations + No Call-No Shows for Therapy Appointments

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 **\$50 late cancellation fee** that will be due at your next visit. After 3 cancellations of less than 24 hours' notice, you will be removed from your scheduled appointment time and will instead be placed on our cancellation list.

If you no call-no show for your scheduled appointment, you will be subject to a **\$75 no call-no show fee** that will be due at your next visit. After 2 no call-no shows, you will be removed from your scheduled appointment time and will instead be placed on our cancellation list.

Cancellation List

Our cancellation list is a scheduling list for those whom weekly scheduled times is not a good fit. Clients on the cancellation list can call the office at the start of each week and scheduled into a cancelled appointment slot. Our office may also call through the list to schedule these clients into cancelled appointment times. This is a good option for those with hectic schedules, frequently changing schedules, or who are otherwise not able to commit to a reoccurring weekly or bi-weekly time slot.

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: _____

Name: _____

Organization: _____

Organization: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

Name: _____

Name: _____

Organization: _____

Organization: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Fax: _____

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: _____