LIMITLESS PROGRAM REGISTRATION AND CONSENT FORM

Child Name:	Sex: M F	Date of Birth:
Home Address:		Home Phone: Cell Phone:
Mother's Name:		Father's Name:

In case of emergency, your contact numbers **(please include yours)** will be called in the order they are listed below.

Contact Name	Relationship To	Phone Number

Physician Name:	Physician #:
Hospital Name:	Hospital #:

Allergies:

Does your child use: Inhaler Epipen

Medication(s) PLEASE NOTIFY US OF ANY CHANGES ARE MADE:

Other Health Concerns:

Signature of Parent or Guardian:_____ Date:_____

Request for Administering Medication at Limitless - Release and Liability

I, the undersigned parent/guardian of the child listed above, a Limitless student, hereby request Integrated Therapy Services P.C to administer the following medications: _____

_____

while attending Limitless Academy. The medicine is to be furnished by me and labeled by the physician or pharmacist with said child's name, doctor, drug store, name of drug and the specific time it is to be given at Limitless. I assume all responsibility for any mistakes in furnishing incorrect dosage. For and in consideration of allowing said child to attend the program in spite of his/her special problem, we hereby release, relieve, and discharge Integrated Therapy Services P.C and/or any of its agents or staff, from any and all liability for any injury or damage to the health of said child arising out of, or resulting from the necessity of said child having to take medication during Limitless hours. I have read, understand, and agree to the regulations concerning giving medication at Limitless.

Signature:_____ Date:_____

Food and Meals

I, the parent or guardian of the child listed above, give permission for Integrated Therapy Services P.C to provide snacks and other foods to my child, as well as assisting them during this process. I acknowledge that I have listed any food allergies that my child has in the section above under "allergies" and release Integrated Therapy Services P.C and all employees/staff from any liability arising from injury resulting from improper chewing, meal preparation, or allergic reaction from an allergen not listed above, including accidental ingestion of an allergen through food provided. I understand it is my responsibility to prepare and include a daily snack and lunch for my child each day they are at the Limitless Program if not participating in therapeutic meal plans at Integrated Therapy Services P.C.

Signature:_____ Date:_____

Ointment and First Aid Permission

I, the parent or guardian of the child listed above, give permission for any staff member of Integrated Therapy Services P.C to apply the following ointments and to administer first aid to my child as needed. I will not hold Integrated Therapy Services P.C staff responsible for any allergic reactions that may occur.

Please Initial the following ointments that may be applied to your child's skin.

_____ Hydrocortisone (used for bug bites and itching)

_____ Triple Antibiotic Ointment (used for scrapes and cuts)

_____ I never want any cream or ointment applied to said child

Signature:_____ Date:_____

Field Trip/Travel Permission

I, the parent or guardian of the child listed above give permission for said child to go on field trips for the Limitless Program. I understand that said field trips may be walking field trips. I understand that said field trips may be done by travel by motor vehicle; including bus or privately owned vehicles. With this knowledge, I hereby consent to our child traveling to, from, and during this trip in either of these manners. I understand that as the parent/guardian of the child, I am responsible for providing the necessary car seat/booster seat as indicated by Illinois law. I further understand that Integrated Therapy Services P.C is not responsible for any damages or accidents that may result from our child's action or the actions of others during said field trip(s).

I hereby also give consent for our child to receive emergency medical care during this trip.

☐ I do give consent for my child to attend field trips and be transported during the Limitless Program

☐ I do not wish to consent for my child to travel with individuals from the Limitless Program and understand it is my responsibility to provide transportation so they may participate in scheduled events.

Signature:_____ Date:_____

Limitless Program Attendance

I, the parent or guardian of the child listed above, understand and acknowledge that each child is enrolled in the Limitless Program based individually on several factors and siblings will be required to receive their own acceptance into the program to receive services if applicable. As the parent or guardian, I understand that it is my sole responsibility to ensure I have adequate plans to ensure the child listed above will be at the Limitless Program during regular hours on a consistent basis and Integrated Therapy Services P.C does not provide child care or accommodations for siblings who are not enrolled in the program.

I agree to have the child listed above at the Limitless Program location at the start time and have transportation available at the end time. I understand the facility may not be available for entry prior to the program start time and there are no assurances that supervision will be readily available prior to or following program hours unless previously arranged with Integrated Therapy Services P.C. I acknowledge and understand reliable consistent attendance at the Limitless

Program is paramount to the program's ability to remain operational and agree to make arrangements with Integrated Therapy Services P.C for any planned absences that arise. Furthermore, I acknowledge Integrated Therapy Services P.C's right to bill for cost associated with any special accommodations made for my child on days my child is absent from the program. This includes but is not limited to any 1-on-1 aide, therapy technician, or floor time player assigned to my child.

Signature:_____ Date:_____

Pool/Sunscreen Permission

I, the parent or guardian of the child listed above, give permission for Integrated Therapy Services P.C and its staff to transport said child to and from the Newton Aquatic Center or the Workman Center indoor pool in Effingham with prior notification. I give permission for said child to participate in swimming activities. I also understand that it is my duty to supply said child with proper swimwear attire and a towel. I give permission to Integrated Therapy Services P.C staff to administer sunscreen to said child as needed. I am aware that staff of Integrated Therapy Services P.C will be present to assist said child with dressing/undressing as needed. We further understand that aquatic activities come with inherent risk that may cause injury and/or death. We acknowledge and understand, Integrated Therapy Services P.C is not responsible for any damages or accidents that may result from our child's actions or the actions of others during the time at Newton Aquatic Center or Workman Center indoor pool in Effingham. This includes injuries and accidents up to and including death. I understand, employees of Integrated Therapy Services P.C have not been trained and/or certified in water rescue, or any other emergency care related to the risk associated with aquatic activities and rely on the training and services provided by the Newton Aquatic Center and Workman Center staff and lifeguards to ensure the safety of all individuals, including my child, while engaging in any activity (aquatic and non-aquatic) at their facility.

Signature:_____ Date:_____

Bowling Permission

I, the parent or guardian of the child listed above give permission for Integrated Therapy Services P.C staff to transport said child to and from Parklanes in Newton for bowling activity. I give permission for said child to participate in bowling activity at Parklanes. I further understand that Integrated Therapy Services P.C is not responsible for any damages or accidents that may result from our child's actions or the actions of others during the time at Parklanes. I understand that I will personally be liable for any damage caused by my child, through their activities while at Parklanes.

Signature:_____ Date:_____

Consent to Treat

I, _____ give consent to Integrated Therapy Services, P.C. to treat my child

_____ for the diagnosis of _____.

I understand that all applicable therapeutic services provided during the Limitless Program will be billed to our insurance company. These services may include Speech Therapy, Behavior Therapy, Social Work, Psychology, Nursing, and Occupational Therapy. I also understand that I am responsible for my patient responsibility as indicated by my insurance policy.

Signature:_____ Date:_____

Approved Persons List

On the lines provided below please list the people who are allowed to pick your child up from the Limitless program in the circumstance that the parent/guardian cannot.

Approved Person Name	Phone #

The following individuals DO NOT have permission to engage with my child or staff during the Limitless Program.

_____

_____

Signature:_____ Date:_____

Child Name: _____

Please ***initial and sign*** for those items you give consent for.

I authorize staff of Integrated Therapy Services P.C. to do the following:

____ Apply sunscreen.
____ Change diapers and apply ointment as needed.
____ Assist with toileting and dressing as needed.
____ Apply first aid for minor cuts and scrapes.
____ Administer inhaler or medication as indicated by physician script. (provide script)
____ Transport my child to and from locations within Newton City Limits and Jasper County by bus and/or personal vehicles belonging to staff members for program purposes with prior notice. Bus transport will be by a licensed bus driver.
____ Transport my child to and from locations outside of Jasper County in order to participate in planned field trips given prior notice. (Additional consent will be required at that time.)
____ Take my child, by foot, on walking tours within the Newton area.
____ Feed my children snacks provided by Integrated Therapy Services P.C.
____ Take photo/videos of my child for the purpose of training within ITS.
____ Take photo/videos of my child for the purpose of educating/marketing to the public.
____ Leave messages via the following:
Phone _____ Text _____
____ Share private health information with the below mentioned individuals:

____ Release care of my child to the following individuals with prior notice:

_____ _____
Print Name Relationship to child

_____ _____
Signature Date

LIMITLESS PROGRAM SCHEDULE OF FEES

Service	Fee	Elected Service (please sign)
Fall Tuition	$1000.00	
Spring Tuition	$1000.00	
Fall Semester Floor Time Player (Mon-Thurs)	$3,400.00	
Fall Semester Floor Time Player (Mon-Fri)	$4,200.00	
Spring Semester Floor Time Player (Mon-Thurs)	$3,400.00	
Spring Semester Floor Time Player (Mon-Fri)	$4,200.00	
**Therapeutic services provided based on Integrated Therapy Services P.C fee schedule and applicable insurance coverage		
Total Fee for Selected Services		
Insurance Eligible Services *(still subject to copayment, coinsurance, deductible & out of pocket max)*		

TERMS: By signing below, you agree to the charges and agree to pay the full amount listed above by selecting one of two payment options. The fees listed above are not refundable and cannot be cancelled once enrolled into the Limitless Program.

[Fees.1]

SERVICES RENDERED: The Limitless Program does its best to suit each individual with their own service plan to meet their goals. Through this program, clients receive therapeutic services at the direction of a team, which includes the parent/guardian and licensed professionals. When services are received, they will be billed to the clients account at the standard rate Integrated Therapy Services P.C has assigned to each service. By signing below, you agree to pay for all services received at the direction of your child's team, which are based on their best interest and which meet the standards of best practice.

INSURANCE: By signing below, you give consent to Integrated Therapy Services P.C to bill your account and insurance for therapeutic services received while at the Limitless Program. You agree to pay any balance left on your account that is not covered by insurance or is considered patient responsibility by your insurance plan. Integrated Therapy Services P.C will work with you to help you best understand the insurance coverage you have as it pertains to the services provided through the Limitless therapeutic day program and Meraki Health outpatient care.

ATTENDANCE CREDIT: Integrated Therapy Services P.C offers an attendance credit to clients who are present for 80% of scheduled in-session dates and receive therapeutic services while at the Limitless Program. The credit will be equal to the cost of Tuition each semester the client meets the 80% attendance record. The credit will be applied to the clients account balance to assist with out of pocket cost associated with the services they received. Attendance percentage will be calculated based on absences regardless of reason.

FINANCIAL ASSISTANCE: Integrated Therapy Services P.C has partnered with the Southeastern Illinois Community Foundation to create the "Limitless Fund" specifically for the purpose of providing financial assistance to clients and their families who receive services from Limitless or Meraki Health. The financial assistance program is a non-selective program made available to all clients on a first-come, first-serve basis as funds are available. Any assistance received will be applied directly to your current outstanding account balance. There is no guarantee of funds being available at the time of application and this program does not forfeit any financial responsibility related to an outstanding balance.

DISCLOSURE: We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for the charges above based on your selected payment plan below made at the time of enrollment into the Limitless Program. Additional therapeutic services provided throughout the Limitless Program require

[Fees.2]

payment in full at the time the service is rendered, unless other arrangements have been made with Integrated Therapy Services P.C. If an account is not paid within 90 days or has a balance aged over 90 days and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. Please consider payment plans.

I authorize the staff of Integrated Therapy Services, P.C. to perform any services that are deemed necessary by best practice standards during the diagnosis and treatment process for my child. I also authorize the provider and or managed care organization to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided above.

PAYMENT OPTIONS: Clients can select from one of the following options for their payment schedule (please indicate which payment option you have selected below):

1. Full payment due for each semester payable by August 15th and January 15th of program year for the full balance due for each semester. Fall Semester Payment due no later than August 15th and Spring Semester Payment due no later than January 15th
2. Installment of 10 equal payments paid via automatic payment withdrawl on the 15th of each month, with the first payment due August 15th, and each subsequent payment withdrawn on the 15th of each month following, with the last payment withdrawn on May 15th.

Payment Option Selected _____

Printed Name of Financially Responsible Party for account: _____

Financially Responsible Party Signature: _____

Date signed: _____

[Fees.3]

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

COMPANY NAME: Integrated Therapy Services P.C. d/b/a Meraki Health, d/b/a Limitless

I (we) hereby authorize Integrated Therapy Services P.C to initiate debit entries to my (our):

Health Savings / Checking Account Debit Card

Credit Card

indicated below at the depository or credit card company named below, hereinafter called Financial Institution, to debit the same to such account

FINANCIAL INSTITUTION:
CITY:
STATE:
ZIP CODE:
NAME ON CARD:
CREDIT CARD/DEBIT CARD NUMBER:
EXPIRATION DATE:
3-DIGIT SECURITY CODE:
AMOUNT:
FREQUENCY OF DEBIT:
DATE(S) OF DEBIT:

This authorization is to remain in full force and effect until Integrated Therapy Services P.C receives written notification from me (or either of us) of its termination in such time and in such reasonable opportunity to act on it, no later than 2 business days prior to the scheduled debit. Termination of this authorization may affect eligibility for financial assistance and/or provider discounts on future services.

NAMES (please print):

DATE OF AUTHORIZATION:

SIGNED: