CHILD CLIENT DEMOGRAPHICS

CLIENT INFORMATION

PERSONAL INFORMATION

Clients Full Legal Name: Preferred Name:

Address: Date of Birth:

Cell Ph #: Home Ph #: Email:

Ethnicity: ☐ Caucasian ☐ African American ☐ Asian/Pacific Islander ☐ Native American ☐ Other: ☐ Prefer not to identify

CURRENT HOUSEHOLD MEMBERS

NAME	RELATIONSHIP	D.O.B	OCCUPATION

ADDITIONAL INFORMATION

Primary Care Physician: Clinic/Office Name:

Address: Phone Number:

Are services a result of an accident? ☐ Yes ☐ No

Is this a worker's comp claim? ☐ Yes ☐ No Is any legal action pending? ☐ Yes ☐ No

PARENT/LEGAL GUARDIAN INFORMATION

1st Parent/Legal Guardian Name: Relationship to child:

Address: Date of Birth:

Cell Ph #: Home Ph #: Email:

2nd Parent/Legal Guardian Name: Relationship to child:

Address: Date of Birth:

Cell Ph #: Home Ph #: Email:

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: Relation to Client:

Address: Phone Number:

GUARANTOR (INDIVIDUAL RESPONSIBLE FOR ACCOUNT BALANCE)

Guarantor's Full Legal Name: Relation to Client:

Address: Phone Number:

Employer: Phone #: Email:

HIPPA INFORMATION FORM

OUR LEGAL DUTY

Our practice is dedicated to maintaining the privacy of current and former patients' health and financial information as required by our internal policies and applicable law. We are also required by federal law to give you this notice explaining your rights, our legal duties and privacy practices. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all PHI (Personal Health Information) that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information contained in this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose PHI about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you. Payment: We may use and disclose your PHI to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Your Authorization: In addition to our use of your PHI for treatment, payment or healthcare operations, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this Notice. To Your Family and Friends: We must disclose your PHI to you, as described in the Patient Rights section (Block 3) of this Notice. We may disclose your PHI to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. Persons Involved In Care: We may use or disclose PHI to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your PHI, we will provide you with an opportunity to object to such uses or disclosures.

In the event of your incapacity or emergency circumstances, we will disclose PHI based on a determination using our professional judgment disclosing only PHI that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI. Marketing Health-Related Services: We will not use your PHI for marketing communications without your written authorization. Required by Law: We may use or disclose your PHI when we are required to do so by law. Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. National Security: We may disclose to the military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected PHI of inmate or patient under certain circumstances. Appointment reminders: We may use or disclose your PHI to provide you with appointment reminders (such as voice-mails, emails, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your protected PHI, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request. Requests for access to your protected PHI must be made in writing. Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. You must submit your request in writing to the contact information provided at the top of this notice. Your first request within a 12-month period is free of charge, but our practice may charge you for additional request made within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs. Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the contact information provided at the top of this notice. Your request, in a clear and concise manner should describe; the information you wish restricted, whether you are requesting to limit our practice's use, disclosure or both or to whom you want the limits to apply.

Alternative Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. Your request must be in writing and specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are still entitled to receive this Notice in written form

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the top of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HIPPA OFFICER - Sarah Weiler

HIPPA Office Address – 605 S Van Buren St., Newton, IL 62448

HIPPA Office Website - www.merakishine.com

HIPPA Office Phone - (618)783-7529

☐ I have received this HIPPA Information form electronically at the time of or prior to completing the Client/Patient Intake Forms

DISCLOSURES & FINANCIAL AGREEMENT

FINANCIAL AGREEMENT

CLIENT'S FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED:

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 all services rendered. We do offer a variety of payment options that can be discussed with Meraki Health office staff to assist our clients and families meet their financial obligation for services rendered. All payments are due when billed. If an account is not paid within 90 days of the date the service was originally billed and no financial arrangements have been made, you will be responsible for any legal fees, collection agency fees, and any other expenses incurred in collecting your account.

Any returned check or other form of payment will be subject to a $35.00 non-sufficent funds/returned check fee that will be charged to my client balance. Additionally, Meraki Health reserves the right to seek damages for any returned payment if legal or collection activity is required, which depending on state law may be up to three (3) times the amount of the returned item.

I authorize the staff of Meraki Health to perform any necessary services needed during diagnosis and treatment. I also authorize Meraki Health to invoice my insurance healthcare provider for the services rendered by Meraki Health. I agree and acknowledge that insurance may not cover my services and that I am responsible for the due diligence required to ensure any services I elect for myself or on behalf of a client of whom I am the legal guardian is a covered procedure prior to accepting any service. The Meraki Health office staff will assist in collecting insurance information, however, understand it is still my final responsibility to ensure my medical plan of care will be covered by my insurance provider. Any balance remaining after my insurance claim has been reviewed and paid/denied by my insurance provider is my responsibility to pay upon being billed by Meraki Health for those services

☐ I agree to the payment terms above and to any fees that may result from returned payments and legal/collection activity because of my failure to make timely payments as outlined above

TERMS OF SERVICES AND CANCELLATIONS

CANCELLATIONS:

If a circumstance comes up which you cannot attend a scheduled appointment you must call the Meraki Health office directly at 618-783-7529 to cancel or reschedule or appointment. We ask that all cancellations and reschedules be done 24-hour prior to your scheduled appointment unless an emergency or acute illness arises that prevents you from providing a 24-hour notice. Informing your clinician or other staff of a need to cancel or reschedule an appointment does not constitute you cancelling an appointment as that can only be done directly through the Meraki Health office.

"No-shows" or sessions that are missed without any prior notice will be subject to a $50.00. "No show" fee, which will be added to your client balance and subject to the payment terms outlined above.

MERAKI HEALTH'S RIGHT OF REFUSAL & TERMINATION OF SERVICES:

Meraki Health and its staff reserve the rights to terminate or refuse services when deemed necessary. This decision is at the sole discretion of the Clinical Manager. Additionally there will be instances in which Meraki Health will need to cancel or postpone services due to various reasons, including but not limited to: closing offices, clinician illness, staffing, and schedule conflicts.

Meraki Health and its clinicians reserve the right to take appropriate action as deemed necessary by the Clinical Director if a client cancels more that 3 sessions without rescheduling a time to make up the missed session. This may include but not limited to changing your scheduled time, no longer holding appointment times, and/or discontinuing services.

By becoming a client or the legal guardian of a client you acknowledge this right and agree not to hold Meraki Health, any employee of Meraki Health, or contract hire of Meraki Health liable for exercising this right.

CLIENT'S RIGHT OF REFUSAL AND TERMINATION:

As a client you have the right to refuse any recommended service or treatment plan by consulting with your clinician and/or Clinical Director. To exercise this right, you must refuse service prior to the service being performed. Once a service is performed you are responsible for the associated charges.

Clients of Meraki Health also have the right to terminate their services at any time by contacting the Meraki Health office and notifying us of your intent to terminate your services. If a client "terminates" their services by "no-showing" to their scheduled appointment(s) and not providing advanced notice those will be treated as "no-shows" and will be subject to the "No Show" fee as described above. Terminating services require the client or their legal guardian to contact the Meraki Health office directly at 618-783-7529 and expressing their desire to terminate any or all services

☐ I agree and acknowledge that I have read this document in its entirety and understand its contents. To the best of my knowledge the information I have provided during the Patient/Client intake process is accurate and complete. It is my responsibility to inform the Meraki Health office of any changes to the information I have provided

Financially Responsible Party's Signature: Date:

CONSENT TO CARE

GENERAL CONSENT TO CARE

GENERAL CONSENT

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Integrated Therapy Services P.C d/b/a Meraki Health on an outpatient, office visit, or the Limitless Day/Summer Camp Program basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Therapy Technician or Physician/Therapist Assistant), and other health care providers or the designees under the direction of a licensed therapist, as deemed reasonable and necessary.

I agree and acknowledge the Meraki Health is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine and therapeutic services is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at the Meraki Health facilities.

TELEMEDICINE

I understand that telemedicine (defined as the use of medical/therapeutic information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

TO THE PATIENT

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test/treatment ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

By signing below, you are indicating that (1) you intend that this consent is continuing in the nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

SIGNED CONSENT

I hereby give my consent to treat myself or any minor child/children listed below, which is under the legal age of eighteen (18) years of age, to receive medical care and/or treatment from the providers of Meraki Health. Any care deemed medically necessary may be provided with or without my presence:

CHILDS FULL LEGAL NAME	DATE OF BIRTH

☐ I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Name of individual completing this form:

Signature of client or legal guardian if a minor:

Date:

INSURANCE INFORMATION FORM

CLIENT INFORMATION

Client Name: Date of Birth:

PRIMARY INSURANCE INFORMATION

Insurance Co. Name: Address:

Phone Number: Member ID#: Group#:

Insured's Name: Relation to Client:

Insured D.O.B: Employer:

SECONDARY INSURANCE INFORMATION

Insurance Co. Name: Address:

Phone Number: Member ID#: Group#:

Insured's Name: Relation to Client:

Insured D.O.B: Employer:

ADDITIONAL INFORMATION

Please note: Prior to your first scheduled appointment you will need to provide a copy of the front and back of your insurance card(s). Copies of these cards can additionally be emailed to info@merakishine.com ahead of your scheduled appointment to check or verify coverage.

Please remember:

1. Prior to rendering services our staff will contact your insurance for benefit details.
2. As a courtesy, we will bill your insurance company/file claims on your behalf.
3. We are happy to assist you with any questions or documentation you may need.
4. You are responsible for all charges not covered by insurance and quoting insurance benefits is not a promise of benefits or coverage by your insurance.

MEDICAL INFORMATION RELEASE PERMISSION FORM

CLIENT INFORMATION

Client Name: Date of Birth:

Legal Guardian's Name: Physician/Clinic Name:

Physician/Clinic Phone Number:

Physician/Clinic Address:

ADDITIONAL INDIVIDUALS OR FACILITIES CONSENT GIVEN

Name of individual/facility: Phone Number:

Address:

Name of individual/facility: Phone Number:

Address:

Name of individual/facility: Phone Number:

Address:

Name of individual/facility: Phone Number:

Address:

☐ I agree and acknowledge I am giving consent for Meraki Health to release or receive my medical information or that of my child if under the age of 18 to the individuals or facilities listed above

Signature of Client or Legal Guardian: Date:

DEVELOPMENTAL, SOCIAL, AND MEDICAL HISTORY

CLIENT INFORMATION

Client Name: Date of Birth:

Individual Completing Form: Relation to Client:

PREGNANCY AND BIRTH HISTORY

Describe any infections and/or illnesses that the mother had, if any, during pregnancy:

Describe any unusual stressors that the mother had, if any, during pregnancy:

Describe any depression that the mother had, if any, during pregnancy or postpartum:

Describe any medications that the mother took during the pregnancy, if any:

Did the mother smoke during pregnancy? ☐ Y ☐ N Drink during pregnancy? ☐ Y ☐ N

Describe any drug use or other abuse, if any, that the mother used during pregnancy:

Describe any complications the mother had during pregnancy or birth, if any:

Child was born: ☐ Full Term ☐ Premature: Weeks

Was labor induced: ☐ Y ☐ N Was either used during delivery: ☐ Forceps ☐ Suction

Type of delivery: ☐ Natural ☐ Caesarean Was this a breech delivery: ☐ Y ☐ N

Was child born as a multiple (twin, etc): ☐ Y ☐ N Was umbilical cord around neck: ☐ Y ☐ N

Describe any problems after delivery, if any:

What was the baby's color upon delivery:

Did the child require a NICU stay: ☐ N ☐ Y for days

Child's weight at birth: Child's length at birth:

Any other pertinent information regarding pregnancy/delivery:

FEEDING DEVELOPMENT AND PATTERNS

As an infant my child: ☐ Bottle Fed ☐ Breast Fed

Child had a good suck/swallow/breath pattern: ☐ Y ☐ N

Describe any feeding complications during infancy, if any?

Any issues introducing solids: ☐ Y ☐ N Does child use utensils well: ☐ Y ☐ N

Cleanliness during feeding/eating: ☐ Skilled ☐ Messy

Describe any gagging or vomiting the child has had in relation to feeding, if any:

List any food allergies the child has, if any:

Please describe child's current eating habits (normal, picky, only eats certain textures, etc.):

Please list child's favorite foods:

Type of cup child uses: ☐ Sippy ☐ Closed lid/straw ☐ Open

Did child have any trouble weaning from bottle, pacifier, and/or thumb: ☐ Y ☐ N

Has the child had drooling issues past 2.5 years of age: ☐ Y ☐ N

Please give additional details on feeding issues:

SLEEPING DEVELOPMENT AND PATTERNS

Does child have a regular sleep pattern: ☐ Y ☐ N Does child wake frequently at night: ☐ Y ☐ N

Does child have difficulty falling asleep: ☐ Y ☐ N Does child sleepwalk/ have tremors ☐ Y ☐ N

How many hours does your child sleep: Is your child: ☐ An earlier riser ☐ Slow to awake

Please give additional details on sleeping issues:

BOWEL AND BLADDER FUNCTION AND DEVELOPMENT

Age child was potty trained: Any issues bed wetting since potty trained: ☐ Y ☐ N

Has child EVER had issues with diarrhea: ☐ Y ☐ N

Has child EVER had issues with constipation: ☐ Y ☐ N

Any issues soiling pants since being potty trained: ☐ Y ☐ N

Any regression in toileting skills since being potty trained: ☐ Y ☐ N

Please give addition details on toileting issues:

OVERALL DEVELOPMENT

Did your child meet motor milestones at the appropriate age (ie. Rolling, sitting, etc): ☐ Y ☐ N

Did your child crawl before he/she walked: ☐ Y ☐ N

Has your child EVER walked on toes: ☐ Y ☐ N

Has your child EVER fallen frequently or seemed clumsy: ☐ Y ☐ N

Has your child EVER seemed stiff or limp: ☐ Y ☐ N

As a baby, did your child tolerate tummy time: ☐ Y ☐ N

Please describe anything in the motor development that you feel the child did late, abnormal, or unusual:

Did the child babble as an infant: ☐ Y ☐ N Has your child EVER stuttered: ☐ Y ☐ N

Did your child meet language milestones at the appropriate ages (ie babbling, speaking): ☐ Y ☐ N

Do you feel your child understand most language spoken to them, if not, please explain:

Please give additional info regarding overall development (ie. Did anything stand out or seem unusual):

BEHAVIORS

Describe how your child adapts to new situations and people:

Describe how your child responds to success (doing well in school, finishing a task, etc):

Describe how your child responds to failures (not able to do something, complete a task, etc):

Describe your child's prevalent mood:

PAST THERAPIES

Has your child ever received any of the following therapies, and if so, please indicate by who and/or where:

Speech Therapy: ☐ Y ☐ N

Behavior (ABA) Therapy: ☐ Y ☐ N

Occupational Therapy: ☐ Y ☐ N

Physical Therapy: ☐ Y ☐ N

Floor Time Therapy: ☐ Y ☐ N

Seen a Psychologist: ☐ Y ☐ N

Seen a Psychiatrist: ☐ Y ☐ N

Seen a Social Worker: ☐ Y ☐ N

MEDICAL HISTORY

List any medical diagnosis your child has been given:

Has your child ever had a vision test? ☐ Y ☐ N Test date and results:

Has your child ever had a hearing test? ☐ Y ☐ N Test date and results:

Please list any childhood illnesses and/or diseases:

Please list any serious injuries and/or surgeries:

Please list any assistive devices or medical equipment your child uses (i.e splints, braces, hearing aids):

Does your child have a history of ear infections: ☐ Y ☐ N

Does your child have tubes placed in ears: ☐ Y ☐ N

Does your child ever had seizures: ☐ Y ☐ N

Does your child have any allergies: ☐ Y ☐ N

Please give further explanation for any of the above questions answered yes:

Please list any medication your child is CURRENTLY taking. Include medication name, dosage, reason:

Please list all medications child has PREVIOUSLY taken. Include medication name, dosage, reason:

Please provide any additional information you feel is important regarding the medication currently or previously prescribed to your child:

SCHOOL HISTORY

Name of school or daycare your child attends:

Name any schools your child previously attended:

Has your child ever been retained in a grade: ☐ Y ☐ N

Does your child like school: ☐ Y ☐ N

Is your child in any type of special education course or class: ☐ Y ☐ N

Does your child receive extra help privately: ☐ Y ☐ N

Has the school reported any particular difficulties in any of the following:

☐ Reading ☐ Writing ☐ Math ☐ Spelling ☐ Behavior
☐ Following Directions ☐ Social Interactions ☐ Attention Span ☐ Restlessness
☐ Finishing Tasks ☐ Organizational Skills ☐ Distractibility ☐ Hyperactivity
☐ Getting along with others

Please describe any concerns or issues with the items noted above:

FAMILY HISTORY

Please describe any pertinent family history regarding medical, developmental, or learning:

SOCIAL HISTORY

Describe any trauma or abuse that your child has ever suffered and/or witnessed, if any:

Describe discipline in the home (who disciplines and how, does child respond, etc):

Describe any issues your child has getting along with others (children of all ages and/or adults):

PLAY HISTORY

What are your child's special interests or favorite play things:

Who does your child prefer to play with:

What activities does the child enjoy the LEAST:

Describe any activities your child fears or consistently avoids:

Does your child tend to line things up in play: ☐ Y ☐ N

Describe any extra-curricular activities your child is or was recently involved in:

Please add any additional notes, comments, or concerns that you may have which were not previously covered:

SENSORY PROFILE 2.0

CLIENT INFORMATION

Client Name: Preferred Name:

Gender ☐ M ☐ F Date of Birth: Date Completing Form:

Primary Care Provider: PCP Phone Number:

Caregiver's name: Caregiver's relationship to child:

Name of School/Daycare attending: School/Grade Level:

What order was child born (i.e 1st child, 2nd child):

How many children ages 0-18 have lived at the home of the child in the past 12 months:

PROFILE QUESTIONNAIRE INSTRUCTIONS

The pages that follow contain statements that describe how children may act. Please read each phrase and select the option that best describes how often. Your child shows these behaviors. *Please mark one option for every statement.* **Use these guidelines to mark your responses:**

When presented with the opportunity, my child…

Almost always	responds in this manner **Almost Always** (90% or more of the time)
Frequently	responds in this manner **Frequently** (75% of the time)
Half the Time	responds in this manner **Half the Time** (50% of the time)
Occasionally	responds in this manner **Occasionally** (25% of the time)
Almost Never	responds in this manner **Almost Never** (10% or less of the time)

Quadrant	Item	AUDITORY PROCESSING My child…	Almost Always 5	Frequently 4	Half the Time 3	Occasionally 2	Almost Never 1
AV	1	reacts strongly to unexpected or loud noises (for example sirens, dog barking, hair dryer					
AV	2	holds hands over ears to protect them from sound					
SN	3	struggles to comple tasks when music or TV is on.					
SN	4	is distracted when there is a lot of noise around.					
AV	5	becomes unproductive with background noise (for example fan, refigerator)					
SN	6	tunes me out or seems to ignore me.					
SN	7	seems not to hear when I call his or her name (even though hearing is OK)					
RG	8	enjoys strange noises or makes noise(s) for fun					
		AUDITORY Raw Score	0				

AUDITORY Processing Comments:

Quadrant	Item	VISUAL PROCESSING My child…	Almost Always 5	Frequently 4	Half the Time 3	Occasionally 2	Almost Never 1
SN	9	prefers to play or work in low lighting					
	10	prefers bright colors or patterns for clothing.					
	11	enjoys looking at visual details in objects.					
RG	12	needs help to find objects that are obvious to others.					
SN	13	is more bothered by bright lights than other same-aged children.					
SK	14	watches people as they move around the room.					
		VISUAL Raw Score	0				
AV	15	is bothered by bright lights (for example, hides from sunlight through car windows					

AUDITORY Processing Comments:

Quadrant	Item	TOUCH PROCESSING My child…	Almost Always 5	Frequently 4	Half the Time 3	Occasionally 2	Almost Never 1
SN	16	shows distress durig grooming (for example fights or cries during haircutting, face washing, fingernail cutting)					
	17	becomes irritated by wearing shoes or socks					
AV	18	shows an emotional or aggressive response to being touched					
SN	19	becomes anxious when standing close to others (for example, in a line)					
SN	20	rubs or scratches a part of the body that has been touched					
SK	21	touches people or objects to the point of annoying others.					
SK	22	displays need to touch toys, surfaces, or textures (for example wants to get the feeling of everything)					
RG	23	seems unaware of pain					
RG	24	seems unaware of temperature changes					
SK	25	touches people and objects more than same-aged children					
RG	26	seems oblivious to messy hands or face.					
		TOUCH Raw Score	0				

TOUCH Processing Comments:

Quadrant	Item	MOVEMENT PROCESSING My child…	Almost Always 5	Frequently 4	Half the Time 3	Occasionally 2	Almost Never 1
SK	27	pursues movement to the point it interferes with daily routines (for example can't sit still, fidgets)					
SK	28	rocks in chair, on floor, or while standing					
	29	hesitates going up or down curbs or steps (for example is cautious, stops before moving.					
SK	30	becomes excited during movement tasks					
SK	31	takes movement or climbing risks that are unsafe					
SK	32	looks for opportunities to fall with no regard for own safety (fo example falls down on purpose)					
RG	33	loses balance unexpectedly when walking on an uneven surface					
RG	34	bumps into things, failing to notice objects or people in the way					
		MOVEMENT Raw Score	0				

MOVEMENT Processing Comments:

Quadrant	Item	BODY POSITION PROCESSING My child…	Almost Always 5	Frequently 4	Half the Time 3	Occasionally 2	Almost Never 1
RG	35	move stiffly					
RG	36	becomes tired easily, especially when standing or holding the body in one position					
RG	37	seems to have weak muscles					
RG	38	props to support self (for example holds head in hands, leans against a wall)					
RG	39	clings to objects, walls, or banisters more than same-aged children.					
RG	40	walks loudly as if feet are heavy					
SK	41	drapes self over furniture or on other people.					
	42	needs heavy blankets to sleep.					
		BODY POSITION Raw Score	0				

BODY POSITION Processing Comments:

Quadrant	Item	ORAL SENSORY PROCESSING My child…	Almost Always 5	Frequently 4	Half the Time 3	Occasionally 2	Almost Never 1
	43	gags easily from certain food textures or food utensils in mouth.					
SN	44	rejects certain tastes or food smells that are typically part of children's diet					
SN	45	eats only certain tastes (for example sweet, salty)					
SN	46	limits self to certain food textures.					
SN	47	is a picky eater, especially about food textures.					
SK	48	smells nonfood objects					
SK	49	shows a strong preference for certain tastes.					
SK	50	craves certain foods, tastes, or smells.					
SK	51	puts objects in mouth (for example pencil, hands)					
SN	52	bites tongue or lips more than same-aged children.					
		ORAL SENSORY Raw Score	0				

ORAL SENSORY Processing Comments:

Quadrant	Item	CONDUCT Associated With Sensory Processing My child…	Almost Always 5	Frequently 4	Half the Time 3	Occasionally 2	Almost Never 1
RG	53	seems accident-prone					
RG	54	rushes through coloring, writing, or drawing					
SK	55	takes excessive risks (for example climbs high into a tree, jumps off tall furniture) that compromise own safety					
SK	56	seems more actie than same-aged children					
RG	57	does things in a harder way than is needed (for example wastes time, moves slowly)					
AV	58	can be stubborn and uncooperative					
AV	59	has temper tantrums					
SK	60	appears to enjoy falling.					
AV	61	resists eye contact from me or others.					
		CONDUCT Raw Score	0				

CONDUCT Processing Comments:

Quadrant	Item	SOCIAL EMOTIONAL Responses Associated With Sensory Processing My child…	Almost Always 5	Frequently 4	Half the Time 3	Occasionally 2	Almost Never 1
RG	62	seems to have low self-esteem (for example difficulty liking self)					
AV	63	needs positive support to return to challenging situations.					
AV	64	is sensitive to criticisms.					
AV	65	has definite, predictable fears.					
AV	66	expresses feeling like a failure.					
AV	67	is too serious.					
AV	68	has strong emotional outbursts when unable to complete a task					
SN	69	struggles to interpret body language or facial expression.					
AV	70	gets frustrated easily.					
AV	71	has fears that interfere with daily routines.					
AV	72	is distressed by changes in plans, routines, or expectations.					
SN	73	needs more protection from life than same-aged children (for example defenseless physically or emotionally.					
AV	74	interacts or participates in groups less than same-aged children					
AV	75	has difficulty with friendships (for example making or keeping friends)					
		SOCIAL EMOTIONAL Raw Score	0				

SOCIAL EMOTIONAL Processing Comments:

Quadrant	Item	ATTENTIONAL Responses Associated With Sensory Processing My child…	Almost Always 5	Frequently 4	Half the Time 3	Occasionally 2	Almost Never 1
RG	76	misses eye contact with me during everyday interactions.					
SN	77	struggles to pay attention.					
SN	78	looks away from tasks to notice all actions in the room.					
RG	79	seems oblivious within an active environment (for example unaware of activity)					
RG	80	stares intensively at objects.					
AV	81	stares intensively at people					
SK	82	watches everyone when they move around the room.					
SK	83	jumps from one thing to another so that it interferes with activites.					
SN	84	gets lost easily.					
RG	85	has a hard time finding objects in competing backgrounds (for example shoes in a messy room, pencil in "junk drawer"					
		ATTENTIONAL Raw Score	0				
RG	86	seems unaware when people come into the room.					

ATTENTIONAL Processing Comments:

FOR OFFICE USE ONLY

ICON KEY	
SK	Seeking
AV	Avoiding
SN	Sensitivity
RG	Registration
	No Quadrant

Socre Key	
5	Almost Always = 90% or more
4	Frequently = 75%
3	Half the Time = 50%
2	Occasionally = 25%
1	Almost Never = 10% or less

SCORE SUMMARY

Instructions:

Please read carefully, the detailed hand-scoring instructions in chapter 4 of the Sensory Profile 2 User's Manual. Transfer the item raw scores from the Caregiver Questionnaire. Add each column of raw scores to get the Quadrant Raw Score Totals

FOR OFFICE USE ONLY

Seeking/Seeker	
Item	Raw Score
14	0
21	0
22	0
25	0
27	0
28	0
30	0
31	0
32	0
41	0
48	0
49	0
50	0
51	0
55	0
56	0
60	0
82	0
83	0
Score Total	0

Avoiding/Avoider	
Item	Raw Score
1	0
2	0
5	0
15	0
18	0
58	0
59	0
61	0
63	0
64	0
65	0
66	0
67	0
68	0
70	0
71	0
72	0
74	0
75	0
81	0
Score Total	0

Sensitivity/Sensor	
Item	Raw Score
3	0
4	0
6	0
7	0
9	0
13	0
16	0
19	0
20	0
44	0
45	0
46	0
47	0
52	0
69	0
73	0
77	0
78	0
84	0
Score Total	0

Registration/Bystander	
Item	Raw Score
8	0
12	0
23	0
24	0
26	0
33	0
34	0
35	0
36	0
37	0
38	0
39	0
40	0
53	0
54	0
57	0
62	0
76	0
79	0
80	0
85	0
86	0
Score Total	0

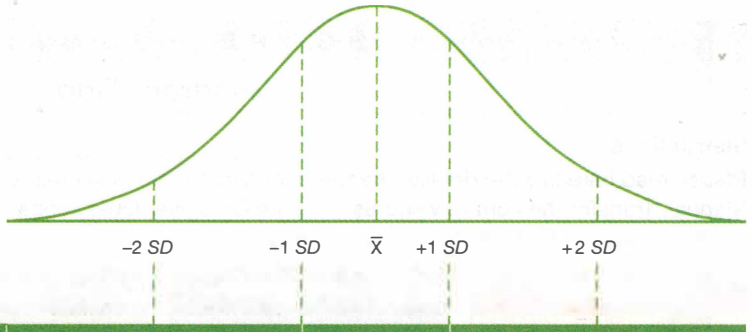
Summary Scores

Instructions

Transfer each Quadrant Raw Score Total from the Quadrant grids to the corresponding Quadrant Raw Score Total box. Then, transfer the section Raw Score Totals from the Caregiver Questionnaire to the corresponding Raw Score Total box. Plot these totals by marking an X in the appropriate classification column (e.g., Less Than Others, More Than Others, Just Like the Majority of Others).

The Normal Curve and Sensory Profile 2 Classification System

Scores one standard deviation or more from the mean are expressed as More Than Others or Less Than Others, respectively. Scores two standard deviations or more from the mean are expressed as Much More Than Others or Much Less Than Others, respectively.



				◄ Less Than Others			More Than Others ►	
		Raw Score Total	Percentile Range[a]	Much Less Than Others	Less Than Others	Just Like the Majority of Others	More Than Others	Much More Than Others
Quadrants	Seeking/Seeker	0 /95	0.00%	0-------6	7-------19	20-------47	48-------60	61-------95
	Avoiding/Avoider	0 /100	0.00%	0-------7	8-------20	21-------46	47-------59	60-------100
	Sensitivity/Sensor	0 /95	0.00%	0-------6	7-------17	18-------42	43-------53	54-------95
	Registration/Bystander	0 /110	0.00%	0-------6	7-------18	19-------43	44-------55	56-------110
Sensory Sections	Auditory	0 /40	0.00%	0-------2	3-------9	10-------24	25-------31	32-------40
	Visual	0 /30	0.00%	0-------4	5-------8	9-------17	18-------21	22-------30
	Touch	0 /55	0.00%	0	1-------7	8-------21	22-------28	29-------55
	Movement	0 /40	0.00%	0-------1	2-------6	7-------18	19-------24	25-------40
	Body Position	0 /40	0.00%	0	1-------4	5-------15	16-------19	20-------40
	Oral	0 /50	0.00%	**	0-------7	8-------24	25-------32	33-------50
Behavioral Sections	Conduct	0 /45	0.00%	0-------1	2-------8	9-------22	23-------29	30-------45
	Social Emotional	0 /70	0.00%	0-------2	3-------12	13-------31	32-------41	42-------70
	Attentional	0 /50	0.00%	0	1-------8	9-------24	25-------31	32-------50

[a] For percentile ranges, see Appendix A in the Sensory Profile 2 User's Manual.
** No scores are available for this range.

Quadrant Definitions	
Seeking/Seeker	The degree to which a child *obtains* sensory input. A child with a Much More Than Others score in this pattern seeks sensory input at a higher rate than others.
Avoiding/Avoider	The degree to which a child is *bothered* by sensory input. A child with a Much More Than Others score in this pattern moves away from sensory input at a higher rate than others.
Sensitivity/Sensor	The degree to which a child *detects* sensory input. A child with a Much More Than Others score in this pattern notices sensory input at a higher rate than others.
Registration/Bystander	The degree to which a child *misses* sensory input. A child with a Much More Than Others score in this pattern misses sensory input at a higher rate than others.

LIMITLESS PROGRAM AND SUMMER CAMP REGISTRATION

REGISTRATION INFORMATION:

Name of Child(ren) and date of birth being enrolled into Limitless Program and/or Summer Camp:

NAME:	DOB:	T-SHIRT SIZE

Summer Camp: $500 # of children being enrolled:

Limitless Program: # of children being enrolled:

Additional Services: Charges for Add'l Services:

TOTAL DUE:

TERMS:

By signing below, you agree to the charges and agree to pay the full amount listed above in addition to any additional charges because of any therapeutic services rendered. The fees listed above are not refundable and cannot be cancelled once enrolled into the Limitless Program or Limitless Summer Camp and no refunds will be given. Any payment plans must be entered into prior to the child's attendance in the Limitless Program and/or Limitless Summer Camp.

SERVICES RENDERED:

The Limitless Program and Limitless Summer Camp does its best to suit each individual with their own service/treatment plan to meet their individual goals. Through this program clients may receive therapeutic services at the direction of a guardian and/or licensed professional. In cases which these individual services are received, they will be billed to the client's account at the standard rate Meraki Health has assigned to each service code. By signing below, you agree to pay for all services received at your direction or the direction of a licensed professional in the best care of your child.

INSURANCE:

By signing below, you give consent to Meraki Health to bill your account and insurance(s) for any therapeutic services received while at the Limitless Program and/or Summer Camp. You agree to pay any balance left on your account that is not covered by insurance or is considered an out-of-pocket expense, including deductible, co-pay, or coinsurance. Meraki Health will work with you to help you best understand the insurance coverage you have as it pertains to the services provided through the Limitless Program and Meraki Health.

FINANCIAL ASSISTANCE:

Meraki Health offers income-based financial assistance through the Limitless Fund. The financial assistance program is available to all clients of Meraki Health on a 'first come, first serve' basis. Any assistance received will be applied directly to your current outstanding account balance. You can ask the Meraki Health office for more information on this program.

CARE CREDIT:

Meraki Health has partnered with Care Credit to offer a flexible payment option to clients, which they can apply for and receive a credit card with promotional rates to be used towards your Meraki Health account balance as well as thousands of other medical offices in the United States. If you are interested in Care Credit, please ask the Meraki Health office for information and to apply.

PAYMENT PLANS:

Meraki Health offers customized payment plans for our clients based on their individual needs. Charges that are required to be paid prior to attendance such as registration or tuition fees may not be eligible for payment plans. Charges towards therapeutic services are eligible for payment plans and if you are unable to pay your balance in full, we encourage you to contact us to make a payment arrangement and set you up with a regularly scheduled automatic payment that fits your budget.

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 all charges based on the services received at the Limitless Program and/or Limitless Summer Camp. Additional therapeutic services provided throughout the Limitless Program and/or Limitless Summer Camp are to be paid in full at the time the services are rendered, unless other payment arrangements have been made with Meraki Health. 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.

☐ I authorize Meraki Health staff to perform any necessary services needed during evaluation and treatment of my child(ren) listed above.

☐ I authorize Meraki Health staff to release any information required to process insurance claims on my behalf.

☐ I understand the above information and guarantee this form was completed accurately to the best of my knowledge and understanding. It is my responsibility to inform Meraki Health of any changes to the information I have provided above, including but not limited to, changes to my child's insurance. I understand that I will be financially liable for any delay in providing a change in information or insurance.

☐ I understand that I am responsible financially for the account under the child(ren)listed above. I agree to pay the account as agreed and understand that I am financially responsible for any fees associated with the collection efforts on a past due account

By signing below, I affirm that I have read and understand the contents above and would like to proceed with registering the child(ren) above to the Limitless Summer Camp and authorize a charge to the credit card/debit card included in this packet or have included a check for the registration fee with this registration packet.

Financially Responsible Party:

Financially Responsible Party's Signature:

Date:

LIMITLESS CONSENTS

LIMITLESS PROGRAM AND SUMMER CAMP CONSENT:

NAME:	ALLERGIES:

Does your child(ren) use:

☐ Inhaler ☐ EpiPen ☐ Neither

Please list any health concerns which we should be made aware of:

REQUEST FOR ADMINISTERING MEDICATION – RELEASE OF LIABILITY:
I, the undersigned parent/guardian of the child listed above, a Limitless client, hereby request Meraki Health to administer the below listed medications while attending Limitless program. The medicine is to be furnished by me and labeled by the physician or pharmacist with the child's name, doctor, drug store, drug name, and the specific time it is to be given at Limitless. I assume all responsibility for any mistakes in furnishing incorrect dosage. For an in consideration of allowing said child to attend the program despite his/her special needs, we hereby release, relieve, and discharge Meraki Health 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 necessity of said child having to take medication during Limitless hours.

☐ I acknowledge that I have read, understand, and agree to the regulations concerning giving medication at Limitless and understand my responsibility to update Meraki Health of any changes to the information below.

List and provide specific direction for any medication that you consent Meraki Health to administer:

Medication & Dosage	Frequency	Use/Purpose:	Special instruction (Child):

FOOD AND MEALS:

I, the parent, or guardian of the child listed above, give permission for Meraki Health 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 Meraki Health and all employees/staff from 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. In lieu of having Meraki Health provide snacks and/or other meals, 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.

☐ I acknowledge that I have read, understand, agree, and give my consent to the above statement

☐ I do not agree and/or give consent to the above statement. I understand by not giving consent or agreeing to the statement may impact my child(ren)s ability to enroll and/or participate in the Limitless program(s)

OINTMENT AND FIRST AID PERMISSION:

I the parent or guardian of the child listed above, give permission for any staff member of Meraki Health to apply ointments for minor itching, scrapes, or cuts and to administer first aid to my child as needed. I will not hold Meraki Health staff responsible for an allergic reaction that may occur.

☐ I acknowledge the I have read, understand, agree, and give my consent to the above statement.

☐ I do not agree and/or give consent to the above statement. I understand by not giving consent or agreeing to the statement may impact my child(ren)s ability to enroll and/or participate in the Limitless program(s)

FIELD TRIPS/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(s). I understand that said field trips may be walking field trips. I understand that said field trips may be done by travel of motor vehicle; including bus, van, or privately owned vehicles of staff members which may or may not be covered by insurance. With this knowledge, we hereby consent to our child traveling to, from, and during these trips in either of these manners. We further understand that Meraki Health is not responsible for any damages or accidents that may result from our child's action or the actions of others during said field trips. In addition, we hereby give consent to Meraki Health and its staff to provide our child with emergency medical care during this trip if they deem necessary and will not hold Meraki Health or any of their employees/staff liable for cost associated to such medical care

☐ I do give consent for my child to attend field trips and be transported during the Limitless program(s)

☐ 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. If no transportation can be provided during scheduled trips, I understand it is my responsibility to provide and transport my child to childcare services for the duration of the trip and Meraki Health will not be responsible for providing care during these times.

LIMITLESS PROGRAM ATTENDANCE:

I, the parent, or guardian of the child listed above, understand, and acknowledge that each child is enrolled into the Limitless program(s) individually based 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(ren) listed above will be at the Limitless Program during regular hours on a consistent basis and Meraki Health does not provide childcare 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 pick up my child at their scheduled pick-up 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 Meraki Health. 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 Meraki Health for any planned absences that arise. Furthermore, acknowledge Meraki Health's right to bill for cost associated to 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.

☐ I acknowledge the I have read, understand, agree, and give my consent to the above statement.

☐ I do not agree and/or give consent to the above statement. I understand by not giving consent or agreeing to the statement may impact my child(ren)s ability to enroll and/or participate in the Limitless program(s)

POOL/SUNSCREEN PERMISSION:

I, the parent, or guardian of the child listed above, give permission for Meraki Health and its staff to transport said child to and from the Newton Aquatic Center and the Limitless program(s). I give permission for said child to participate in swimming activities. I also understand that it is our duty to supply said child with proper swimwear attire and a towel. I give permission to Meraki Health staff to administer sunscreen to said child as needed. I am aware that staff of Meraki Health will be present to assist said child with dressing/undressing as needed. We further understand that aquatic activities come with inherit risk that may cause injury and/or death. We acknowledge and understand, Meraki Health does not staff trained swimming lifeguards and 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, this includes injuries and accidents up to and including death. I understand, employees of Meraki Health may not have been trained and/or certified in water rescue, CPR, 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 staff and lifeguards to ensure the safety of all individuals, including my child and staff, while engaging in any activity (aquatic and non-aquatic) at their facility.

☐ I acknowledge the I have read, understand, agree, and give my consent to the above statement.

☐ I do not agree and/or give consent to the above statement. I understand by not giving consent or agreeing to the statement may impact my child(ren)s ability to enroll and/or participate in the Limitless program(s)

BOWLING PERMISSION:

I, the parent, or guardian of the child listed above give permission for Meraki Health staff to transport said child to and from Parklanes and the Limitless program(s) for bowling activity. I give permission for said child to participate in bowling activity at Parklanes. I further understand that Meraki Health 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.

☐ I acknowledge the I have read, understand, agree, and give my consent to the above statement.

☐ I do not agree and/or give consent to the above statement. I understand by not giving consent or agreeing to the statement may impact my child(ren)s ability to enroll and/or participate in the Limitless program(s)

APPROVED PERSON LIST:

The following individuals are allowed to pick up my child(ren) listed above from the Limitless program(s) or any of the activities they hold in circumstances which I am unable to pick up my child(ren).

FIRST AND LAST NAME	PHONE NUMBER

Please list below any individuals who do not have your permission to engage with the child listed above during the Limitless program(s).:

FIRST AND LAST NAME	RELATIONSHIP TO CHILD

GENERAL SUMMARY OF CONSENT:

I, the parent, or guardian of the child(ren) listed above, authorize the staff of Meraki Health 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
- ☐ Transport my child(ren) to and from locations as indicated above
- ☐ Take my child(ren) by foot on walking tours within the Newton area
- ☐ Feed my child(ren) snacks provided by Meraki Health and/or the parent

☐ Take photos/videos of my child(ren) for the purpose of training within Meraki Health

☐ Take photos/videos of my child(ren) for the purpose of educating/marketing to the public

ACKNOWLEDGEMENT OF UNDERSTANDING AND AGREEMENT:

By signing below, I acknowledge that I have read and understand all the sections of this document and have responded to each section in accordance with my consent or non-consent. I acknowledge I am fully liable for any harm done because of my misunderstanding and/or failure to disclose information.

Parent or legal guardian name who completed this form:

Signature of the above individual: Date:

RE: Updates to Client Payment Policy

Meraki Health Patients:

In a continued effort to maintain pricing below the industry averages Meraki Health has reviewed our payment policy and will be making the following changes:

Effective November 1, 2022, Meraki Health will implement a change to our payment policy as it pertains to all active and past patients with a statement balance due. Meraki Health will begin to require a credit card guarantee to be on file for all patients at the time of scheduling their appointments. The credit card guarantee will remain on file for the period of time which services are being rendered and/or a balance remains.

Effective November 1, 2022, all patients with a balance will be sent a balance statement the first week of each month. Patients will have until the 20th of the month to make their payment by cash payment, check, or returning the portion of the statement with credit card payment information. Individuals wishing to pay from a Health Savings Account or any method other than a credit card will need to pay the balance prior to the 20th of each month to pay in this manner. Any outstanding statement balance unpaid prior to the 20th of each month will be charged to the credit card on file being held as the guarantee.

Each patient will need to complete and return the enclosed credit card guarantee form and ensure they maintain an active credit card on file while receiving Meraki Health services. Any account without a credit card guarantee returned at this time will be required to complete one prior to scheduling any future sessions. Any account that falls past due without prior payment arrangements in place will be subject to termination of services until the account is brought current or payment arrangements are made for past due balances.

We appreciate your continued support and ask you to call our office with any questions or concerns you have regarding this change in policy or any other matter.

Thank you,

Meraki Health

PAYMENT GUARANTEE PREAUTHORIZATION AGREEMENT

I/We hereby authorize Integrated Therapy Services P.C. d/b/a Meraki Health to initiate a debit on the 20th of each month for the remaining monthly statement balance for the following patients if payment is not received prior to the 20th of the month for the monthly statement balance due:

Patient's Name(s):

The credit or debit card listed below shall serve as a guarantee of payment for the above listed patient(s):

Bank or Credit Card Company:

Name on Card: Card Number:

Expiration Date: 3-Digit Security Code:

Cardholder Billing Street Address:

City: State: Zip Code:

Email address for payment confirmations (optional):

By completing and signing this Payment Guarantee Preauthorization Agreement you are agreeing to have any monthly statement balance remaining on your account debited from the credit or debit card listed above on the 20th of the month or if closed, the next business date. If the payment is declined Meraki Health will continue to run the card daily until the transaction is approved. This authorization is to remain in full force and effective for the duration of your treatment plan with Meraki Health. All patients of Meraki Health are required to have a credit card guarantee on file and may change the credit or debit card they would like deducted by completing a new Payment Guarantee Preauthorization Agreement 2-days prior to the scheduled debit day.

Signature of Cardholder: Date Signed:

PAYMENT METHODS

Below is a breakdown of the payment options available to our clients and the different methods available for paying the monthly statement balance and/or services related to their treatment plan:

- Contacting the Meraki Health office and requesting access to the Therabill Client Portal where you can view your past and current balance statements and receipts as well as make credit card payments directly from the client portal.
  This is offered free of charge to our patients and is the best way to view balance statements, receipts, notes, sessions, etc. for the patient, as well as making credit card payments if you wish to pay your balance statement with credit or debit card prior to the 20th of each month

- Mailing a check to Meraki Health, PO Box 13, Newton, IL 62448 for the balance statement amount due and ensuring there is plenty of time for the postal service to deliver the payment prior to the 20th of each month.
  This is the best method if you are wanting to pay from a Health Savings account by check or if wanting to pay through your bank's bill pay system.

- Stopping by our office to pay with cash, check, or credit card during regular business hours, Monday-Thursday 8am-4pm and Friday 8am-1pm.

- If you prefer to pay at the time of service our office can accept cash, check, or credit card payments to be credited to your account at that time. Please note, patients with insurance can be provided an estimate for their responsibility at the time of service, however, the final patient responsibility my differ after insurance processing resulting in a credit balance or additional balance due.

- If you prefer to have your card on file charged on the 20th of the month, you do not have to do anything, and we will charge the balance statement amount automatically on the 20th of the month or the next business day if the office is closed on the 20th of the month.

- Insurance payments – Patients with insurance are only billed for the service once insurance processing has finalized. In some cases, your insurance company may take several weeks to process the claim, resulting in charges on the monthly statement from sessions that occurred several weeks in the past reflecting the deductible or co-insurance the patient is responsible to pay.

- Care Credit – Meraki Health has partnered with Care Credit, which is a credit card company specifically for medical related expenses, to offer our patients 0% financing for 12 months through special promotional pricing options. If you are an existing Care Credit card holder this offer is already available to you. If you would like to apply for Care Credit you can speak to the Meraki Health office, and we can complete and submit the application for you with an instant credit decision.
  This is a great option for patients who will have a larger balance on their monthly statement due to having a deductible remaining or larger co-insurance patient responsibilities or our cash pay client. Our office can estimate the cost of services related to your treatment plan and use your Care Credit card to pay for the services so you can pay for your services over a 12-month period.