Child's Initials: _____ **Date:** _____

Austin's Communication Station
www.ACSkids.com
7800 Shoal Creek Blvd. Ste 110W
Austin, TX 78757
info@ACSkids.com
Phone (512) 610-1190 Fax (512) 610-1191

Welcome to Austin's Communication Station!

Thanks for choosing to have your child evaluated by our therapists here at Austin's Communication Station. We are looking forward to meeting with you and your family!

What to expect:

1. Call our office and do a phone interview so we can develop a basic understanding of your child's needs and check your insurance benefits.

2. Fill out the attached initial intake questionnaire. Please return this to us ***at least 4 Days prior to your evaluation appointment***. This questionnaire helps the clinicians prepare testing materials, and fun toys/movies/snacks for the appointment. Most importantly, it provides insight on what your goals are for your child's therapy.

3. Please gather any reports from other doctors or specialists (for example: previous speech/occupational therapy clinic, Primary Care Doctor, Neurologist, ENT, Psychologist, Psychiatrist, etc.). Also, please bring a copy of your child's school ARD/IEP if applicable. We will copy this information and use it for reference at the clinic.

4. Day of Evaluation
    A. Please bring **your government issued ID and your current insurance card** for us to copy. Also, please bring the packet of clinic forms with all policies (or you can get a copy from us when you arrive). Once you have signed all forms you will receive a copy for your records as well.
    B. We will go over the plan for the evaluation and you will get to take a tour of the clinic so you are able to see the layout and various types of spaces we have.
    C. The therapists will come out to the waiting room to greet you and your child. Our goal is to complete testing within the first few therapy appointments, while trying to collect as much information as we can about your child.
    D. Your child will be guided back to the evaluation room and given the option to get a snack and some water. Once they are settled in, we will begin testing. You are welcome to observe the evaluation from the adjoining room (through the one-way window).

   i. Speech Therapy Evaluations: focus on testing for articulation, language, executive functioning, social communication skills, etc.
   ii. Occupational Therapy Evaluations: focus on testing fine motor, gross motor, sensory processing, activities of daily living, etc.

E. Children usually complete the initial appointment within 1-3 hours (depending on age and other factors). Once they are finished, the therapist will bring you back to discuss how the testing went, give you some preliminary results, and share their recommendations with you. *You are also more than welcome to ask questions at this time.*

F. On your way out, we will confirm upcoming scheduled appointment times.

5. During the first few appointments the clinicians will continue to gather information through interaction and further testing. This will help us accurately develop their individualized goals.

6. The Initial Speech and Language or Occupational Therapy Assessment report will be prepared for your review approximately 4-6 weeks after the initial assessment appointment. The speech therapy report will consist of extensive information regarding speech/ language, oral motor, executive functioning, and social communication objectives for your child for speech therapy. While the occupational therapy report will include fine motor, gross motor, sensory processing, activities of daily living, etc. The reports will review how your child performed in each of these categories.

Please let us know if you have any questions or concerns. We are very excited to meet you and your child soon!

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Attendance, Cancellations and Rescheduling

Attendance is a key factor in the success of your child's program and in our ability to help him/her and your family succeed. It is very important that your child attends therapy regularly and does his/her homework. We designate your regularly scheduled time to your child. Your therapist plans individually therapy based activities for your child and commits a portion of his/her time preparing for your child's session.

CANCELLATIONS

Austin's Communication Station (ACS) Inc. requires a 24-hour cancellation notice for therapy sessions and a 48-hour cancellation notice for evaluations. These timeframes allow us ample time to fill your cancelled time slot with make-up or wait-listed appointments. You can cancel appointments via phone 512-610-1190 (leaving a message is sufficient to provide notice of cancellations), or email at info@ACSkids.com.

If you cancel with less than 12-hour notice, a $50 cancellation fee is charged to you and is due upon your next monthly invoice. *Insurance companies do not cover cancelled appointments*. If you reschedule your appointment it will nullify the cancellation fee as long as the appointment takes place within 14 business days of your cancelled appointment. This rescheduling is subject to availability of the therapists' schedules.

If client has excessive cancellations:

- If your child attends therapy 1-2 sessions a week—you are allowed 3 cancellations in 6-month period: (Jan 1-June 30; and July 1-Dec 31)
- If your child attends therapy 3 or more sessions a week—you are allowed 5 cancellations in a 6-month period: (Jan 1-June 30; and July 1-Dec 31)

Regardless of advanced notice, a $50 a session charge will be imposed if the above cancellation limits are exceeded and if session is not made-up within 14 business days of your cancelled appointment. If you cancel but you are able to reschedule your appointment and attend the rescheduled therapy session, it will nullify this $50 charge.

NO SHOWS

If you do not call and "no show" for an appointment you will be charged a $75 fee and this fee is due on your next monthly invoice.

Child's Initials: _____ Date: _____

You may reschedule a no-show appointment nullifying the cancellation fee by rescheduling your appointment to take place within 14 business days of the appointment you missed. *Insurance companies do not cover no show charges.* Two, consecutive "no show" appointments without contacting our office, constitutes removal from the schedule.

ACCIDENTS AND ILLNESS HAPPEN

Accidents and illness may strike at the last minute leaving no choice but to cancel your appointment with less than 12 hours notice. If you or your child is sick, you may provide a physician's note corroborating the illness and you will not be charged. We will be happy to reschedule the appointment when you or your child gets well.

Children cannot attend therapy services if they have an infection or contagious disease (example: fever, chicken pox, measles, thrush, impetigo, pink eye, strep, hepatitis, stomach virus, vomiting, diarrhea, etc.). Also, if your child has been kept home from school due to illness, he/she should not attend therapy. People must be fever and vomiting/diarrhea free for at least 24 hours before attending therapy sessions.

If any member of your family has an infection or contagious sickness/disease, please do not allow the sick person to come into Austin's Communication Station, Inc. It is very important that we watch out for the health of other children and our staff.

If your child has a fever, vomits or has diarrhea during their therapy session, you will be contacted and must leave the clinic immediately. Should your therapist become ill, you will be scheduled at your normal time with another therapist or notified and rescheduled when there is an available time.

RESCHEDULING MISSED APPOINTMENTS

You may make up your missed appointment within 14 business days at no charge. We will try to schedule you with your regular therapist. If this is not possible, your make up appointment may be scheduled with another therapist. The therapist seeing your child for your make-up appointment will contact your regular therapist about your treatment goals and activities prior to your make-up appointment.

**Rescheduling of appointments is always subject to availability of the therapists.

I have read and understand the above cancellation and attendance policy. I agree to abide by the conditions listed above.

_____ _____

Signature of legal representative of child Date

Child's Initials: _____ Date: _____

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Financial Responsibility Form

Thank you for choosing Austin's Communication Station, Inc. for your pediatric therapy services. We are committed to providing the best therapy for our clients. We treat each client as an individual and their therapy progress is our primary concern, but patient financial responsibility is a major source of difficulties in the medical billing process. In order to improve our office efficiency, reduce overhead expenses, and ensure that we can financially sustain ourselves in order to continue providing our patients the services they are accustomed to, the following form outlines specific details about how the insurance process works and thus reduces communication issues by clearly outlining the insurance company's portion as well as the portion for which you, the client, is responsible.

Please note that clients are required to notify us of any insurance company and/or any information changes, while receiving services from Austin's Communication Station, Inc. Clients will be held financially liable for all costs incurred if they do not disclose correct coverage. Please provide Austin's Communication Station, Inc. with a copy of your insurance each time you receive a new card and/or your insurance information changes.

You are required to inform Austin's Communication Station, Inc. if you have any type of secondary insurance coverage (including Medicaid). Failure to inform us of this may cause therapy costs to become the responsibility of the client.

The benefit information given to us by your insurance company is an estimate and not a guarantee of payment. In addition, as we check your benefits and submit claims to your insurance company, insurance companies may occasionally request additional information to process claims. If required, our billing department will request that you provide the needed information to your insurance company so that the claims can get processed and paid. Please follow-up with our billing department or your insurance company if you have any questions.

All caregivers are expected to know and understand their coverage and benefits for therapy services. Although we will verify insurance benefits prior to your first appointment, you may also check your benefits by calling the phone number on your insurance card and speaking with a representative from the insurance company. It is very important that you ask specifically about any "exclusions" or "limitations" to therapy benefits. A quote of benefits from your insurance company is not a guarantee of payment. In the event your insurance chooses not to pay for services, you are ultimately responsible for all charges.

Austin's Communication Station, Inc. will file insurance claims with your insurance company to ensure services are covered and you know the extent of your financial responsibility. Austin's Communication Station, Inc. is in-network with several major insurance companies, including most HMO's and PPO's plans. We also will bill out-of-network claims for other insurance companies.

We will do our best to answer any insurance related questions. Any follow-up questions regarding non-payment after our initial appeals process is your responsibility. **If payment is not issued by the insurance company within 90 days of initial filing, you are responsible for payment IN FULL for all services rendered. It is then your responsibility to follow-up with the insurance company regarding any further appeals.** Please understand that if your insurance company delays payments or is waiting on additional information before they render payment, and the balance due is past 90 days, the balance is your responsibility and is due immediately.

Child's Initials: _____ Date: _____

If we are not filing insurance for you, payment for services is due in full at the time of service.

Co-payments, co-insurances and deductibles are expenses that the provider is expected to collect. As your provider, it is our responsibility to collect co-payment, co-insurance, and/or deductible amounts defined by your insurance company. **Co-pays/Co-insurances/Deductibles will be invoiced monthly and due within 14 days of the invoice.** However, if this policy is abused and the client does not pay within 14 days of being invoiced, Austin's Communication Station, Inc. reserves the right to remove this privilege and payment will be due at each therapy visit.

Processing and late fees are presented immediately after your invoice goes 60 days past due with no attempt to contact Austin's Communication Station, Inc. to arrange payment. The following fees will incur:

- Processing fee of $25.00 per month until a payment is made to your account.
- 5% late fee of total account balance accrued monthly until a previously agreed upon payment is made towards the due balance.

Any portion of the therapy fees not reimbursed by your insurance company are your responsibility.

You are responsible for payment of any no-show appointments, short notice appointments or too many cancellations, as insurance companies will NOT reimburse these charges. Please see the cancellation and attendance section of this packet for specific details.

Austin's Communication Station Inc. will provide offsite consultations at the request of the client. This service is not usually covered by insurance and therefore you will be billed at the standard hourly fee for the clinic. Patients are responsible for full payment of this service prior to the consultation.

Our office accepts checks, cash, and some debit/credit cards.

For returned checks, we assess a $35.00 NSF charge and report to the local district attorney's office.

If not paid according to terms, the patient understands that our office may report to an outside collection agency. In the event that your account is turned over for collections, the patient ultimately responsible for all fees sustained in the collection of the debt.

I hereby accept all responsibility for treatment costs not covered or reimbursed by third party payers. I also acknowledge that I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to Austin's Communication Station, Inc. including copayments/coinsurance, deductibles, and amounts due for non-covered services or services that are not payable by my insurance.

_____	_____	_____
Responsible party and/or trustee of patient's funds	Date	Austin's Communication Station Inc. Representative Signature

ASSIGNMENT OF BENEFITS

I hereby authorize the _____, Company to pay directly to Austin's Communication
Insurance Company Name
Station Inc., all benefits that may be due to me, if any, by reason of services described in the statements rendered, and as provided for in the above policy contract with aforementioned insurance company. I understand that Austin's Communication Station Inc., which has accepted assignment, has the same right as I do to appeal carrier's determination.

_____	_____	_____
Patient or Patient's agent	Date	Austin's Communication Station Inc. Rep Signature

Child's Initials: _____ **Date:** _____

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Holiday Preferences and Clinic Schedule

Clinic Schedule

Austin's Communication Station Inc. will be closed on the following holidays: New Year's Eve, New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving, Friday after Thanksgiving, Christmas Eve, Christmas Day.

In December, Austin's Communication Station Inc. is closed for the week between Christmas and New Year's Day. (from Christmas Eve until the first business day after New Year's Day).

In case of inclement weather, Austin's Communication Station, Inc. follows the school closings for Austin Independent School District. If you see that AISD is closed due to inclement weather, ACS will be closed as well. If AISD starts school on a delayed schedule (ex. two hours late), ACS will start the schedule for the clinic at that delayed time. Appointments missed during the time we are closed for the delay can be then be rescheduled (ex. If the weekly appointment is at 8:30 and AISD starts on a two-hour delay, the 8:30 appointment will have to be rescheduled to another time/date.).

In the event that AISD is on holiday/vacation and the Austin area experiences bad weather, you will be notified as soon as possible by Austin's Communication Station, Inc.'s via email, text or phone call about the plans for the ACS schedule.

Holiday Preferences

We at Austin's Communication Station Inc. enjoy celebrating some holidays by doing various art projects, reading books, playing with thematic toys, and possibly having small holiday celebrations. Our activities will always be about the secular (non-religious) aspects of the holiday. Please let us know if your family **does not celebrate** the secular aspects of any of these holidays below or if you would rather us **not** have your child participate in the holiday themed activities:

Please mark the blank if you do **NOT** wish for your child to participate in the holiday themed activities:

_____ MLK day/ President's Day

_____ Valentine's Day

_____ St. Patrick's Day

_____ Easter

_____ Independence Day

_____ Halloween

_____ Thanksgiving

_____ Christmas

_____ _____

Parent/Guardian Signature **Date**

Updated by ACS Management Jan 2019

Child's Initials: _____ **Date:** _____

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PHOTOGRAPH AND VIDEO RELEASE FORM

I hereby authorize Austin's Communication Station, Inc. to photograph or video my child for the purposes of treatment, education and professional reasons. I also understand that my child may be in group pictures or videos that may also be viewed by others outside of Austin's Communication Station, Inc.

ACS will use recordings to document baseline information during the initial evaluation process and to gather further information for a more in-depth view of your child's presented skills. We also often use video and photographs to document progress throughout therapy.

No names will be disclosed with use of any pictures or video for education and/or marketing purposes

I grant permission to photograph/videotape my child during therapy sessions for use in (**please check the applicable boxes**):

□ education of parents and other professionals

□ brochure or marketing materials

□ on Austin's Communication Station, Inc.'s website

□ on Austin's Communication Station, Inc.'s Facebook page.

We occasionally put these pictures up on the walls in the treatment area. Parents or other clients may ask the names of the children in the pictures. I authorize that my child's first name only may be revealed when referring to these pictures.

This authorization is valid for the duration of my child's therapy from the date signed below. I understand that I may revoke this authorization at any time, but will not hold Austin's Communication Station, Inc. responsible for use of pictures or video already taken of my child.

Parent's Signature: _____ Date: _____

Child's Initials: _____ **Date:** _____

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Child Pick-Up Authorization Form

The following designated person(s) are authorized to pick-up my child, _____, from Austin's Communication Station, Inc. Parents/Guardians or designated pick-up people will be responsible for the child inside and outside of the building when picking up and dropping off my child. Austin's Communication Station accepts no responsibility or liability if a child is injured in the company of or while supervised by a parent, guardian or designated authorized pick-up person.

_____	_____	_____
Guardian	*Relationship*	*Phone Number*
_____	_____	_____
Guardian	*Relationship*	*Phone Number*
_____	_____	_____
Guardian	*Relationship*	*Phone Number*
_____	_____	_____
Guardian	*Relationship*	*Phone Number*

I authorize Austin's Communication Station, Inc. to verbally share information regarding my child's session with those listed above for the purpose of continuity of care. Also, if I have any questions or concerns regarding my child's session, I acknowledge that I have 48 hours (after the sessions complete) to contact my child's therapist via phone or E-mail to discuss matters further.

_____ _____
Parent/ Guardian Signature *Date*

I **DO NOT** authorize the following person or persons to pick-up my child from Austin's Communication Station, Inc.

_____	_____
Person's Name	*Relationship*
_____	_____
Person's Name	*Relationship*

_____ _____

Child's Initials: _____ Date: _____

Parent/ Guardian Signature *Date*

Children will not be allowed to leave with anyone not recognized and authorized by Austin's Communication Station, Inc. and its staff. A child will not be released to individuals without written consent from the parent or legal guardian. Based on the opinion of Austin's Communication Station, Inc.'s staff, if parent/guardian or designated pick-up person appears to be impaired, the child will not be released.

It is the parents' or legal guardians' responsibly to keep this authorization form up-to-date. Please complete a separate authorization for each child. Please list any legal custody information we should be aware of on a separate sheet and attach it to this form. Bring this form to Austin's Communication Station on or before the first day of appointment.

I release Austin's Communication Station, Inc. from any and all responsibility once the above authorized persons take my child from Austin's Communication Station's waiting room.

_____ _____

Parent/ Guardian Signature *Date*

Child's Initials: _____ **Date:** _____

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Child Pick-Up Policy Acknowledgment

I acknowledge Austin's Communication Station's "Attendance, Cancellations and Rescheduling" policies. I understand that if I leave the clinic during my child's therapy sessions, I am required to be back in the clinic 15 minutes before the end of my child's scheduled session. I also understand that I **must** call if I am running late. If I am not back 10 minutes before the end of the session, I forfeit my privilege of talking with my child's therapist about his/her session.

If I am not back at the scheduled end of the session (end of one hour), Austin's Communication Station, Inc. will have to allocate staff resources to watch my child, so I may be charged $5.00 per minute that I am late. If the above authorized pick-up person is late more than two (2) times with no justifiable reason, I understand that authorized caregiver will not be allowed to leave during his/her therapy session.

_____ _____
Parent/ Guardian Signature Date

Child's Initials: _____ **Date:** _____

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Client Food Allergy Information

Snacks are often used as part of your child's therapy session at Austin's Communication Station, Inc. Please sign below if you consent to your child receiving and consuming snacks during his or her therapy session.

Do you consent to _____ receiving snacks during treatment sessions. □**Yes** □**No** _____
Client Name Parent/Guardian Initials

We are committed to providing a safe atmosphere for our clients so please list all your child's known food allergies or restrictions below:

My child _____ has **NO known food allergies**. _____
Client Name Parent/Guardian Initials

My child _____ has **the following food allergies or restrictions**:
Client Name

Please list specific foods such as gold fish, candy, gluten, etc. that you do NOT want your child to consume based on allergies or dietary restrictions:

Please list any reactions to foods or allergens that we should watch for:

_____ _____ _____
Client Name Parent/Guardian Signature Date

Child's Initials: _____ **Date:** _____

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Austin, TX 78757
info@ACSkids.com
Phone (512) 610-1190 Fax (512) 610-1191

Consent to Exchange Medical Information

I hereby authorize: Austin's Communication Station, Inc.
7800 Shoal Creek Blvd. Ste 110W
Austin, Texas 78757
(512)610-1190 phone
(512)610-1191 fax
Email: info@Acskids.com

AND

Name: _____Relationship: _____ Name: _____ Relationship: _____

Name: _____Relationship: _____ Name: _____ Relationship: _____

Name: _____Relationship: _____ Name: _____ Relationship: _____

Name: _____Relationship: _____ Name: _____ Relationship: _____

To release and exchange medical information from the medical record(s) of:

Patient's Name: _____
Patient's Date of Birth: _____
Address: _____
City: _____ State: _____ Zip:_____

Information that may be released:

- Copy of Complete medical record(s)
- All other relevant information such as:
  - Initial Evaluation
  - Progress Notes
  - Discharge Summary
  - Re-Evaluations
  - Requests for prescriptions, equipment or updates

*****This release is valid from date this form is signed by patent representative until seven years post discharge from therapy at Austin's Communication Station. Unless revoked in writing or by completing a new form*****

Signature: _____ Date: _____ Relationship to Patient: _____
Patient Representative
ACS Witness: _____ Date: _____

Child's Initials: _____ **Date:** _____

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Schedule Availability

Hello Parents and Caregivers,

Please note below if you are available on the given days and what the earliest time you can safely arrive would be (also please note any time you must be finished by):

Monday: (available?: yes ____ no ____) Times available: _____

Tuesday: (available?: yes ____ no ____) Times available: _____

Wednesday: (available?: yes ____ no ____) Times available: _____

Thursday: (available?: yes ____ no ____) Times available: _____

Friday (only open for sessions 1:30pm to 5:30pm): (available? yes ____ no ____) Times: _____

Thanks very much!!!!

_____ _____
Parent/Caregiver Signature Date

Child's Initials: _____ Date: _____

NOTICE OF
PRIVACY PRACTICES
For Austin's Communication Station Inc.

Effective: April 1st, 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this notice, please contact Austin's Communication Station's Privacy Officer at **(512) 610-1190**

Austin's Communication Station Inc. is required by law to maintain the privacy of your health information; give you notice of our legal duties and privacy practices with respect to your health information; and follow the terms of this notice. This notice applies to all of your health records generated by Austin's Communication Station Inc., whether made by our personnel or your personal physician.
This notice will tell you about the ways in which we may use and disclose your health information at Austin's Communication Station and with other entities. We also describe your rights and certain obligations we have regarding the use and disclosure of your health information as defined by federal and state laws and regulations.

●WHO WILL FOLLOW THIS NOTICE?
Austin's Communication Station Inc.; the medical staff and all practitioners granted clinical privileges at Austin's Communication Station

●HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
For Treatment–We will use your health information to provide you with health care treatment and to coordinate or manage services with other health care providers, including third parties. We may disclose all or any portion of your health information to your attending physician, consulting physician(s), allied health practitioners, nurses, technicians, other facility or health care personnel who have a legitimate need for such information in order to take care of you. Different departments of the facility will share your health information in order to coordinate the health care services you need, such as prescriptions, lab work and X-rays. We may disclose your health information to family members or friends, guardians or personal representatives who are involved with your medical care. We may also use and disclose your health information to contact you for appointment reminders, and to provide you with information about possible treatment options or alternatives, and other health-related benefits and services. We also may disclose your health information to people outside the facility who may be involved in your health care after you leave the facility, such as other physicians involved in your care, specialty hospitals, skilled nursing care facilities and other health care-related services.
For Payment–We will use and disclose your health information for activities that are necessary to receive payment for our services, such as determining insurance coverage, billing, payment and collection, claims management, and medical data processing. For example, we may tell your health plan about a treatment you are planning in order to receive approval or to determine whether your plan will cover the proposed treatment. We may disclose your health information to other health care providers so they can receive payment for health care services that they provided to you, such as ambulance services. We may also give information to other third parties or individuals who are responsible for payment for your health care.
For Health Care Operations–We may disclose your health information for routine facility operations, such as business planning and development, quality review of services provided, internal auditing, accreditation, certification, licensing or credentialing activities, medical research and education for staff, and to other health care entities that have a relationship with you and need the information for operational purposes.

●USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW
Subject to requirements of federal, state and local laws, we are either required or permitted to report your health information for various purposes. Some of these reporting requirements include:

apply to us will be made only with your written authorization. If you provide us with authorization to use or disclose your health information, you may revoke that authorization in writing at any time. When we receive your written revocation we will no longer use or disclose your health information for the purpose of that authorization. However, we are unable to retrieve any disclosures already made based on your prior authorization.

●YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
You have the following rights regarding your health information:
Right to Inspect and Copy–You have the right to inspect your health information and obtain copies of medical, billing or other records that may be used to make decisions about your care. The right to inspect and copy does not apply to psychotherapy notes that are maintained separately from the health record. Submit your request in writing to: Austin's Communication Station Medical Records Department, 7800 Shoal Creek Ste 110W, Austin, TX 78757. We charge a fee for document requests to cover costs of copying, mailing or other supplies. In limited circumstances we may deny your request to inspect and copy your health information. If you are denied access to your health information, you may request that the denial be reviewed. Austin's Communication Station will designate a qualified individual within the center who will review your request and the denial. The person who conducts the review will not be the same person who denied your request. We will comply with the outcome of the review.
Right to Amend–You have the right to request an amendment to your health information that you believe is incorrect or incomplete. You must make your request in writing, using a *Request for Amendment to Protected Health Information* form, and including your reason for the amendment, to: Austin's Communication Station, 7800 Shoal Creek Ste 110W, Austin, TX 78757. To obtain a paper copy of this form, contact Austin's Communication Station at 512-610-1190. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that:
• Was not created by Austin's Communication Station; unless the person or entity that created the information is no longer available to make the amendment;
• Is not part of the medical information kept by or for Austin's Communication Station;
• Is not part of the information that you would be permitted to inspect and copy; or
• Is accurate and complete.
To obtain a paper copy of this request, contact Austin's Communication Station, 7800 Shoal Creek Ste 110W, Austin, TX 78757 512-610-1190.
Right to an Accounting of Disclosures–We are required to maintain a list of disclosures of your health information. However, we are not required to maintain a list of disclosures that we made by acting upon your written authorizations or for treatment, payment or health care operations. You have the right to request an accounting of disclosures that were not subject to your written authorization or for treatment, payment or health care operations. Submit your request in writing to Austin's Communication Station, 7800 Shoal Creek Ste 110W, Austin, TX 78757.. Your request must state a time period, not longer than six years, and may not include dates before January 05, 2008. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.
Right to Request Restrictions–You have the right to request a restriction or limitation on how much of your health information we use or disclose for treatment, payment or health care operations. You also have the right to request a restriction on the disclosure of your health information to someone who is involved in your care or payment for your care, such as a family

Child's Initials: _____ Date: _____

Public Health Activities–We may disclose your health information to public health officials for activities such as the prevention or control of communicable disease, injury or disability; to report births and deaths; to report suspected child abuse or neglect; to report reactions to medications or problems with medical products; to report exposures to environmental hazards; and to report results of lead testing.
Disaster Relief Efforts–We may disclose your health information to an entity assisting in a disaster relief effort so that your family can be notified about your condition and location.
Health Oversight Activities–We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.
Judicial or Administrative Proceeding–We may disclose your health information in response to a court or administrative order, a valid subpoena, discovery request, civil or criminal proceedings, or other lawful process.
Law Enforcement–We may release your health information if asked to do so by a law enforcement official:
• In response to a court order, subpoena, warrant, summons or similar legal process;
• Regarding a victim or death of a victim of a crime in limited circumstances;
• In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime, including crimes that may occur at our facility.
Coroners, Medical Examiners and Funeral Directors–We may release health information to a coroner or a medical examiner. This may be necessary, for example, to identify a person who died or determine the cause of death. We may also release health information to help a funeral director to carry out his/her duties.
To Avert a Serious Threat to Health or Safety–We may disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public.
National Security–We may disclose your health information to federal official(s) for national security activities and for the protection of the President and other Heads of State.

●OTHER USES OF YOUR HEALTH INFORMATION
Other uses and disclosures of your health information not covered by this notice or the laws that

member or friend. ***We are not required to agree to your request***. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. You must make your request in writing to Austin's Communication Station, 7800 Shoal Creek Ste 110W, Austin, TX 78757, by submitting a request for *Restrictions to Protected Health Information* form. You must include: (1)what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply. To obtain a paper copy of this form, contact Austin's Communication Station, 7800 Shoal Creek Ste 110W, Austin, TX 78757 512-610-1190.
Right to Request Confidential Communications–You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask that we only contact you at an alternative location from your home address, such as work, or only contact you by mail instead of by phone. You must make your request in writing to Austin's Communication Station, 7800 Shoal Creek Ste 110W, Austin, TX 78757, by submitting a *Confidential Communications Opt Out* form. Your request must specify how or where you wish to be contacted. We do not require a reason for the request. We will accommodate all reasonable requests. To obtain a paper copy of this form, contact Austin's Communication Station Medical Records Department, 7800 Shoal Creek Ste 110W, Austin, TX 78757 or by phone at 512-610-1190.
Right to a Electronic/Paper Copy of This Notice–You have the right to an electronic and paper copy of this notice. You may ask us to give you a copy of this notice at any time. If you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a paper copy of this notice by contacting Austin's Communication Station, 7800 Shoal Creek Ste 110W, Austin, TX 78757, 512-610-1190.

●CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the facility. The notice will contain on the first page, in the top right-hand corner, the effective date. Upon your initial registration or admittance to the facility for treatment or health care services as an outpatient, we will offer you a copy of the current notice in effect. Whenever the notice is revised, it will be available to you upon request.

●COMPLAINTS
You may file a complaint with us or with the Secretary of the Department of Health and Human Services if you believe that we have not complied with our privacy practices. You may file a complaint with us orally or in writing by contacting Austin's Communication Station privacy officer at 512-610-1190 or 7800 Shoal Creek Ste 110W, Austin, TX 78757

Child's Initials: _____ **Date:** _____

Austin's Communication Station
www.ACSkids.com
7800 Shoal Creek Blvd. Ste 110W
Austin, TX 78757
info@ACSkids.com
Phone (512) 610-1190 Fax (512) 610-1191

Consents and Acknowledgements for 2019

Consent for Care and Treatment: *Please Read and Initial:* _____

As the child's parent or legal guardian, I hereby consent to necessary evaluation, procedures and/or treatments prescribed by my child's therapist. I understand that my child is under the care and supervision of Austin's Communication Station, Inc.'s staff. I authorize release of medical information to Austin's Communication Station Inc.'s staff for continuity of care.

Acknowledgement of Notice of Privacy Practices: *Please Read and Initial:* _____

I acknowledge that Austin's Communication Station, Inc. will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. The Notice of Privacy Practices provides further detailed information about how the use and/or disclosure of protected medical information about your child.

Your signature below indicates that you have been given an opportunity to review and offered a copy of Austin's Communication Station, Inc's Notice of Privacy Practices on the date below. If you have any questions regarding the information in Austin's Communication Station, Inc's Notice of Privacy Practices, please do not hesitate to contact Austin's Communication Station Inc's Patient Privacy Officer, Justin Jones.

Consent to Communication: *Please Read and Initial:* _____

As the child's parent or legal guardian, I hereby acknowledge that my child's session will be discussed with the adult, authorized on the child pickup forms, who is picking up the child. I understand that I can contact my child's therapists via phone or email up to 48 hours after the session to discuss any questions or concerns. If a caregiver is unavailable after the session completes, it is my responsibility to contact my child's therapist if I have any questions or concerns. This is to ensure understanding and the accuracy of the information presented by the therapist.

Consent to Escort to the Restroom: *Please Read and Initial:* _____

I permit a staff member of Austin's Communication Station, Inc. to escort my child to the restroom, if necessary, during therapy sessions. I also consent to the staff member helping my child in the restroom if needed (ex. Wiping, cleaning up from an accident, changing clothes after an accident etc.).

Notification of Austin's Communication Station, Inc.'s Staff as Mandated Reporters *Please Read and Initial:* _____

Texas laws (i.e. Chapter 261 of the Texas Family Code) requires professionals with knowledge of suspected child abuse or neglect to report suspicions to appropriate authorities. I understand that the staff of Austin's Communication Station, Inc. is required to report such concerns to the Texas Department of Family and Protective Services (DFPS). DFPS investigates reports of child abuse and neglect in the state of Texas.

Child's Initials: _____ Date: _____

Inclement Weather Policy: *Please Read and Initial:* _____

In case of inclement weather, Austin's Communication Station, Inc. follows the school closings for Austin Independent School District. If you see that AISD is closed due to inclement weather, ACS will be closed as well. If AISD starts school on a delayed schedule (ex. two hours late), ACS will start the schedule for the clinic at that delayed time. Appointments missed during the time we are closed for the delay can be then be rescheduled (ex. If the weekly appointment is at 8:30 and AISD starts on a two hour delay, the 8:30 appointment will have to be rescheduled to another time/date.).

In the event that AISD is on holiday/vacation and the Austin area experiences bad weather, you will be notified as soon as possible by Austin's Communication Station, Inc.'s via email, text or phone call about the plans for the ACS schedule.

Consent for Observation: *Please Read and Initial:* _____

I acknowledge that Austin's Communication Station, Inc. conducts therapy sessions (both individual and group) that will be observed at times by other professionals and university students to study our therapy techniques. Sessions will be observed by these professionals or students and at times they may participate in treatment sessions. Confidential information about my child will not be shared with these professionals or students other than what is necessary to plan an effective lesson. At any time, our professional or student interacts with a client from our clinic, they will be accompanied by an Austin's Communication Station, Inc. clinician. All planning by professional or student will be implemented only after it's been approved by the lead clinician.

I understand that while observing their own child's therapy sessions, other caregivers may also see my child in therapy at Austin's Communication Station, Inc. However, these caregivers will also be bound by this confidentiality agreement concerning personal health information.

In my observations at Austin's Communication Station, Inc. I agree to keep confidential any and all protected health information about the persons observed or discussed within the scope of this clinical experience. I acknowledge that this protected health information is part of Austin's Communication Station, Inc's policy as well as Federal and State Law and any violation could result in criminal or civil prosecution.

Acknowledgement of Risk from Therapy Materials and toys: *Please Read and Initial:* _____

I acknowledge that there is some risk inherent in the use of therapy equipment and toys at this clinic. I agree to indemnify and hold Austin's Communication Station, Inc. harmless from any and all losses and claims for any injuries or other damage occurring to myself, my child, or our belongings from the use of therapeutic equipment.

Acknowledgement of Risk from Therapy incentives and prizes: *Please Read and Initial:* _____

I hereby release Austin's Communication Station, Inc from any and all liability resulting in any possible injury caused to the child who has been treated, their siblings, family members and/or pets, caused by toys and/or prizes given to my son/daughter as part of their patient incentives (prizes), or therapy materials/ projects sent home.

Consent for Varied Therapy Location: *Please Read and Initial:* _____

Most therapy sessions will be performed within the Austin's Communication Station, Inc's office suites (110W, 115W, 135W). However, I consent to my child sometimes experiencing therapy sessions that take place within other locations at 7800 Shoal Creek Blvd, Austin, TX 78757. These other locations may include the outside courtyard, inside atriums, hallways, other building suites, sidewalk outside, restrooms, parking lot etc. In these locations, my child will be in the presence of other adults and/or children, outdoor temperatures, sun, insects, etc. I understand that it is my responsibility to notify the front office if my child is not allowed to go outside of the suite or outside the building.

Child's Initials: _____ Date: _____

Group Parent Talk Times: *Please Read and Initial:* _____

Austin's Communication Station, Inc's philosophy includes a "group" parent talk time following group therapy sessions. During this time, it is understood that the therapist(s) will speak openly to all the parents of all the children in the group with regard to the participation and skills the children need to work on at home.

Illness Policy *Please Read and Initial:* _____

Children cannot attend therapy services if they have an infection or contagious disease (example: fever, chicken pox, measles, thrush, impetigo, pink eye, strep, hepatitis, stomach virus, vomiting, diarrhea, etc.). Also, if your child has been kept home from school due to illness, he/she should not attend therapy.

If any member of your family has an infection or contagious sickness/disease, please do not allow the sick person to come into Austin's Communication Station, Inc. It is very important that we watch out for the health of other children and our staff. People must be fever and vomiting/diarrhea free for at least 24 hours before coming into ACS. It is very important that we watch out for the health of other children and our staff.

If your child has a fever, vomits or has diarrhea during their therapy session, you will be contacted and must leave the clinic immediately. Should your therapist become ill, you will be scheduled at your normal time with another therapist or notified and rescheduled when there is an available time.

Consent for Use of Food during Sessions: *Please Read and Initial:* _____

Austin's Communication Station, Inc. will attempt to follow any restrictions concerning any food allergies/sensitivities and/or, family dietary preferences. Austin's Communication Station, Inc. often gives children snacks and/or use food during therapy sessions. I agree to notify Austin's Communication Station, Inc. immediately if there are any changes to the foods my child is allowed to have/not have during sessions. I hereby release Austin's Communication Station, Inc from any and all liability resulting in any possible reactions caused by food to the child who has been treated, their siblings, family members and/or pets; as long as Austin's Communication Station Inc. is following dietary guidelines provided to them by me.

Consent for Communication via Email: *Please Read and Initial:* _____

□**Yes** □**No** Do you consent for Austin's Communication Station Inc. to contact you by e-mail regarding your child's progress, scheduling, or billing issues?

Consent for Communication via SMS/Text Message: *Please Read and Initial:* _____

□**Yes** □**No** Do you consent for staff from Austin's Communication Station Inc. to contact you by SMS/text message regarding your child's care?

Consent for Communication via Voicemail: *Please Read and Initial:* _____

□**Yes** □**No** Do you consent for staff from Austin's Communication Station Inc. to leave voicemails on the numbers you have provided for contact regarding your child's care?

I have read and understand the above policies, consents and procedures and have been given an opportunity to ask questions about the policies. I understand that I will be asked to review these annually and that each time the policies are updated I will be asked to review them again.

_____	_____	_____
Child's Name	Signature of legal representative of child	Date