Rebecca Pokluda, P.C.
KidWorks therapy services

3607 Manchaca Rd., Austin, TX 78704 • 512-444-7219 Phone • 512-444-6005 Fax

WELCOME TO KIDWORKS!!!

We would like to take this opportunity to welcome you to **KidWorks (KW)** and to thank you for choosing our services for your child and your family. We are dedicated to providing quality Occupational, Speech and Language, and Physical Therapy services using a family-centered approach! Your entire family will benefit from the services, support and education that will be offered. This approach will assist not only your child, but also your family in understanding and overcoming the various challenges that your child faces.

KidWorks is committed to the wonderful and vast fields of Occupational, Speech and Language, and Physical therapy. We encompass a wide range of therapeutic methods and interventions that your whole family will learn to understand, enjoy and benefit from. **KidWorks** emphasizes a professional environment of diverse experience, on-going continuing education and a progressive approach to new concepts in this ever growing and changing field. This is crucial in providing you with the most current information and treatment possible.

KidWorks takes great pride in giving your child and your family undivided attention and time. It is very important to work in a nurturing environment that meets the individual needs of your child. In addition, education and support are provided to your entire family because the difficulties and challenges that your child faces affect everyone involved. Our therapy process focuses on emotional and social development within a relationship based model utilizing DIR/Floortime principles. You and your child deserve nothing less.

Welcome to the **KidWorks** team! A marvelous journey of exploration, challenge, fear, excitement and hope lies ahead. Together, we will face this journey to help your child grow, improve and gain successful experiences that will enhance their life and your family's as well.

Please contact us directly with any concerns.

The Management Team at KidWorks Therapy:

Rebecca Pokluda, Clinic Director
Liz Darwin, Assistant Clinical Director

CREATING SOLUTIONS….. CREATING SUCCESS

General Guidelines

The following information is a list of general guidelines that will assist in creating a treatment environment that is as efficient and smooth as possible. If you have any questions, please speak with your therapist.

1. Please have your child dressed in clothing that is easy to move in and is OK if it gets dirty.

2. If you want to observe the treatment session, please discuss this with your therapist first. Due to the HIPAA privacy laws there is a specific procedure that must be followed to ensure the privacy of other clients in the gym.

3. Parents are required to be present in treatment for the last 10 minutes. The last 10 minutes of the treatment session may be used for family education, discussion and documentation. If you feel that you need additional time to discuss issues, please schedule that time with your therapist. This will prevent running into the next appointment. If you leave the clinic during your child's therapy time, please return to 10 minutes prior to the end of the session to allow ample time for therapist to discuss the session and complete documentation.

4. You will be notified as far in advance as possible when your therapist is ill, on vacation or attending a conference. Every effort will be made to reschedule your appointments so that your child will miss as little treatment as possible.

5. A client may be sent home because of a health need if he/she:
   - Appears ill and is unable to participate in therapy.
   - Is suspected of having a contagious disease/condition.
   - Sustains an injury which needs medical attention or close observation.
   - Has active head lice.
   - Exhibits vomiting and diarrhea during school hours.
   - Has a fever of 100.4 or greater (a client may not return to KidWorks until fever free for 24 hours off of fever reducing medication such as Tylenol or Motrin).
     *If the client is restricted or limited in any way due to illness or accident, a note from the doctor at the time of the client's return to therapy may be required.

7. Please leave information on how to contact you if you do not stay for the treatment hour in case of any emergencies. Also, please be prompt in picking up your child before their session is over. We do not have the means for childcare. Failure to return in a timely manner more than one time will result in a requirement that you do not leave the premises during your child's treatment.

8. Cancellation Policy: Please provide 24 hour notice to cancel an appointment. A charge will be incurred if less than 3 hour notification is provided to cancel an appointment. Voicemail may be used to cancel an appointment through the office.

9. It is essential to maximize therapeutic gains of intervention that you consistently attend your regularly schedule appointments. Missing more than 50% of your scheduled sessions within any 4 week period or if you have 3 "no show" cancellations within one year will result in the loss of a reserved treatment time slot. We highly encourage rescheduling appointments when you need to cancel.

10. It essential for the success of your child's treatment that you attend your scheduled sessions. There is also a high demand for treatment at our practice. For these reasons if more than 3 consecutive weeks of treatment are missed, your reserved appointment time will be forfeited if another client is waiting for that spot. Your child will be placed on the waiting list for another time slot. Thank you for your consideration in this situation.

11 E-mail Policy: Email may be used to cancel an appointment 24 hours prior to an appointment or to request a schedule change. We ask for you to communicate all schedule changes with your therapist. kidworkscommunity@gmail.com
(Please Note) *This email is only used for cancellations or scheduling changes. If you have something that you need to discuss with your therapist please speak to them in person at the time of your child's appointment.*

Rebecca Pokluda, P.C.
KidWorks therapy services
3607 Manchaca Rd, Austin, TX 78704 • Ph 512-444-7219 • Fax 512-982-4331

Dear Parents,

The purpose of this letter is to clarify our expectations, as well as the expectations you should have from KidWorks. Our therapeutic intervention utilizes a framework of the DIR model of care:

D: Development Levels- The **D (Developmental)** part of the model describes the building blocks of this foundation. Understanding where the child is developmentally is critical to planning a treatment program. The D part of DIR refers to the Functional Emotional Developmental Level of the child. It is also essential to take into consideration the motor, emotional, language, and social developmental levels.

I: Individual Differences- The **I (Individual Differences)** part of the model refers to the neurological makeup of what makes us unique. The term describes the various processing issues that make up a child's individual differences and that may be interfering with his/her ability to learn.

R: Relationship- The **R (Relationship-based)** part of the model describes the learning relationships with caregivers, educators, therapists, peers, and others who tailor their affect based interactions to the child's individual differences and developmental capacities to enable progress in mastering the essential foundations.

In order to reach our common goal of supporting your child in reaching his/her highest potential, we have several guidelines that will allow the therapist, office staff, and parents to begin with the same understanding.

1. Therapy sessions range from 25 minutes to 50 minutes of skilled intervention with last ten minutes for communication with parent, documentation of treatment and clean up. This includes:
    a. Exercises and activities with the child
    b. Parent education- Last 5-10 minutes
    c. Home program education which includes exercises and activities to supports goals, parent training, handouts to describe recommended activates, and anything related to your child's treatment plan.
    d. Ongoing communication for any schedule changes.

2. It is essential that you are on time for your therapy session to get the maximum benefit. Therapy sessions will end promptly at the scheduled time.

3. For additional consult and planning needed outside of regular session you may schedule a separate meeting with your therapist.

    a. For face to face and/or phone consults less than 15 minutes there is no charge Anything exceeding 15 minutes will be charged.
    b. Additional time over your child's appointment with your therapist must be scheduled.
    c. Some insurance companies do not pay for parent consultation/education. Additional meetings with your therapist will be your responsibility.

4. If you have any questions related to billing or insurance please call our Billing Specialist:

    Crystal Castillo
    (512) 444-7219

5. Developing a trusting and respectful relationship is essential for the therapy process. Both parents and therapists are responsible to develop this trusting relationship. If at any time you have questions or comments about your child's therapy please discuss it with your therapist. If at any time you have additional concerns or questions please schedule a meeting with Liz Darwin, Assistant Clinical Director, or Rebecca Pokluda, Clinical Director.

6. We are committed to assisting all family members in this healing process. Having a child with any difficulties is stressful for the while family. To meet this need we may recommend family and child counselors and behavior specialists

Again, we are committed to you and your child. Thank you for allowing us to serve your child.

Rebecca Pokluda, Clinical Director
Liz Darwin, Assistant Clinical Director

DEMOGRAPHIC INFORMATION

INFANT FORM (BIRTH TO 12 MONTHS)

Child's Full Name: _____ **DOB:** _____

Mother/Guardian's Name: _____

Address: _____ Zip code_____

Home Phone: _____ Work Phone: _____ Cell: _____

Occupation: _____ Employer: _____

Father/Guardian's Name: _____

Address: _____ Zip code_____

Home Phone: _____ Work Phone: _____ Cell: _____

Occupation: _____ Employer: _____

Living Situation**:** (circle one) Married Single Divorced/Separated Other

Email Address: _____

INSURANCE INFORMATION:

Primary Insurance Co. _____

Provider Phone Number: _____

Insured: _____ Insured DOB: _____

ID Number: _____ Group No. _____

Secondary Insurance Co. _____

Provider Phone Number: _____

Insured: _____ Insured DOB: _____

ID Number: _____ Group No. _____

I hereby give KidWorks Therapy Services authorization to file claims for services rendered on my behalf. Any claims that are not paid or authorized by the insurance carrier will be my responsibility.

_____ _____

Responsible Party Signature **Date**

BIOLOGICAL INFORMATION

Child's Name: _____ **DOB**: _____

Name of Person completing this form: _____ **Relationship to child:** _____

Siblings: _____ Age: _____ Grade: _____

_____ Age: _____ Grade: _____

_____ Age: _____ Grade: _____

E-mail Address:_____

What language(s) are spoken in the home? What is the primary language spoken?

_____

Current concerns/reason for
referral:_____

_____

When was the concern, first noticed? By whom?_____

_____

Has the concern/ problem changed since it was first noticed?

_____

_____

MEDICAL INFORMATION:

Please circle all that apply and/or fill in the blanks.

Physician: _____ Phone: _____
Diagnosis: Seizure disorder, Autism, Neurofibromatosis, Tongue tie (ankyglossia), Down syndrome, CP, ASHD, OCD, ODD, Encephalopathy, Other:_____
_____

Does your child see other specialist(s)?
Physician:_____Specialty:_____

Physician:_____Specialty:_____

Other Professional Providers: (occupational, physical or speech therapy) etc): *please list names of therapists*

_____

_____

Do other family members have any speech, motor, cognitive, or other disorders/delays? If yes, please describe:

_____

_____

_____

DEVELOPMENTAL MEDICAL HISTORY

The following questions are posed to help in compiling a more complete picture of your baby. Please answer the following questions as best you can. If there is not adequate space for your comments, please continue to write on the back of this form. Thank you very much for taking the time to complete this history. It will help us greatly!

MOTHER'S PREGNANCY AND CHILD'S BIRTH:

Please circle *Yes* or *No* to the following questions and remark in the space provided.

1. Were there any infections/illnesses during pregnancy? Yes No _____

2. Were there any drugs or medications taken during pregnancy? Yes No _____

3. Was there any unusual stress during pregnancy? Yes No _____

_____

4. Was the pregnancy full-term? Yes No Weeks of pregnancy? _____

5. Was the labor normal? Yes No (Specify) _____

_____

6. Was the delivery normal? Yes No (Specify) _____
(Cesarean section, breech, sideways, cord around neck, forceps used)

7. Was medication given during delivery? Yes No _____

8. Were there any other complications during the pregnancy? Yes No _____

_____

9. What was the child's weight at birth? _____

10. Were there any complications? Seizures jaundice congenital defects other: _____

11. Was there a need for: oxygen transfusions tube feedings other: _____

12. Did your infant cry right away? _____

13. Did your infant have a hearing test? What were the results? _____

13. What was the length of the infant's hospital stay? _____

14. Is your infant currently breast fed, bottle fed, tube fed or a combination?
_____

15. Are you concerned about your infant's feeding?
_____

16. Are you experiencing feelings that may be depression, anxiety or sadness that are worrisome? Are you having any difficulties adjusting to your new life and schedule? Yes No

17. Would you like us to provide information about possible sources for help? _____

_____

18. Please state any other difficulties or special cares: _____

Please feel free to attach any hospital discharge or prior therapy information that is important to the care of your infant.

Current health: _____ Current weight: _____ Current length: _____

Date of last physical exam: _____ Results: _____

My child currently sleeps/naps: inconsistently well restless other

My child currently eats/drinks: at regular/irregular intervals consistent/inconsistent amounts

Describe your child's current demeanor/behavior: _____

_____

_____

Current Medications/Dosage/Frequency: _____

_____

_____

Known Allergies (milk, latex, etc):

_____

SOCIAL/ EDUCATION HISTORY:

Who does your infant stay with during the day? _____

Activities your child
enjoys:_____

_____

DEVELOPMENTAL MILESTONES:

Please list the age that your child did the following and answer questions below (in months).

Roll _____ Sit _____ Belly crawl _____ Crawl on hands/knees _____ Walk _____

Run _____ Skip _____ Vocalize _____ Finger feed _____ Use spoon _____

Drink from cup with assistance _____

How do you know when your baby is hungry?:_____

How do you know when your baby is sleepy?: _____

How do you know when your baby needs a new diaper? _____ _____

1.Do you feel that your baby met his/her early milestones on time when compared to peers or siblings?

_____

2. Do you have concerns or questions about his/her development? _____

_____

3. Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, distracted by sounds, etc.):

_____

_____

3. Do you have difficulty getting your infant to calm? _____

4. Are you able to bathe your infant easily? _____

Are there any cultural or religious beliefs that you would like us to be aware of and/or take into consideration when we are working with your child? _____

_____

_____

_____

PLEASE USE SPACE BELOW FOR FURTHER COMMENTS:

Rebecca Pokluda, P.C.
KidWorks therapy services

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PHOTOGRAPH AND VIDEO RELEASE FORM

I authorize KidWorks Therapy Services to photograph my child for use in the following categories. Parents or other clients may ask the names of the children in the pictures. I authorize that my child's first name may be mentioned when referring to these pictures.

This authorization is valid from the date signed below. I understand that I may revoke this authorization at any time, but will not hold KidWorks Therapy Services responsible for pictures already taken of my child.

Please check "Yes" or "No" to indicate your preferences.

I Give KidWorks Permission to:	**Yes**	**No**
Take photographs or video for educational purposes	_____	_____
Use photos within the clinic	_____	_____
Use photos on company website	_____	_____
Use photos in flyers, brochures, or publicity ads	_____	_____
Email to parent of videos taken for educational purposes ***I understand that email may not be HIPAA compliant and that KidWorks will not use email for any other correspondence.*	_____	_____

Name of Child:_____

Parent's Name:_____

Parent's Signature:_____

Date:_____

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CONSENT AND ACKNOWLEDGEMENT

Consent for Care and Treatment: As the child's parent or legal guardian, I hereby consent to necessary evaluation, procedures and/or treatments prescribed by my child's therapist as is necessary in her judgment. I understand that my child is under the care and supervision of my therapist. I authorize release of medical information to the KidWorks team for continuity of care. KidWorks Therapy Services is a teaching facility. There will be students, volunteers, and clinical interns that may be observing or supporting the therapists in treatment areas. I authorize this as a part of my child's treatment at KidWorks Therapy Services.

_____ _____
Signature of legal representative of child Date

Acknowledgement of Notice of Privacy Practices: I acknowledge that KidWorks will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. Our Notice of Privacy Practices provides further detailed information about how we use and/or disclose protected medical information about your child for treatment, payment, healthcare operations, and as otherwise allowed by law.

_____ _____
Signature of legal representative of child Date

Consent for Parent Observation: I understand that other parents may observe my child in therapy as the parents observe their child in therapy.

☐ I consent to the presence of other parents in the same treatment area with my child as the parents observe their child in therapy.

☐ I do not consent to have other parents in the same treatment area as my child.

_____ _____
Signature of legal representative of child Date

Consent for Text/Email: I understand that text/ e-mail is not HIPPA compliant or a confidential method of communication. I further understand that there is risk to text/ e-mail communication between KidWorks and myself may be intercepted by third parties or unintended parties. Text/Email correspondence is solely to be used for brief and logistical matters: scheduling, insurance benefits, and monthly statements. It should not be used for anything related to therapeutic interventions.

☐ I consent for KidWorks to text/email me regarding my insurance benefits, scheduling and my monthly statement.

☐ I do not consent to receive text/emails from KidWorks regarding my insurance benefits, scheduling and my monthly statement.
Email Address _____ Name of child: _____

_____ _____
Signature of legal representative of child Date

_____ _____
Printed Name Date

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PROCEDURE FOR OBSERVING YOUR CHILD IN THERAPY

To ensure compliance with HIPAA, parents are not allowed in the treatment area unless specific arrangements have been made with your therapist.

To maintain the confidentiality of clients during their therapy session, the following procedures must be observed:

1. Parents choosing to observe must sign a statement of confidentiality.

2. While observing your child's therapy, you may be asked to leave the treatment area or the location of your child's therapy. The location may have to be modified if one of the clients in the gym/treatment area requests that no other parents be in the same room as their child during treatment.

3. Siblings are not allowed in the treatment area unless authorized by the treating therapist for therapeutic reasons.

4. Cell phone use is not allowed in the treatment area.

5. Stay only in the area in which your child is working.

6. Please respect the other client's therapy sessions in the event your presence is distracting. **You may be asked to leave the treatment area if your presence is affecting your child or other client's treatment. In the instance when there is more than one person observing, we may ask that only one person be in the treatment area to protect the quality of treatment.**

Statement of Confidentiality

The undersigned hereby acknowledges his/her responsibility under federal applicable law and the Agreement to keep confidential any information regarding KidWorks' patients, as well as all confidential information of KidWorks. The undersigned agrees under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient, and further agrees not to reveal to any third party any confidential information of KidWorks, including policies and procedures.

_____ _____

Client's Name DOB

_____ _____

Guardian's Signature DATE

Authorization for Release and Disclosure of Protected Health Information
In accordance with state and regulatory agency requirements, the medical record is the property of KidWorks.

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

I hereby authorize that my medical information be released:

TO/FROM

_____
_____
_____

KIDWORKS THERAPY SERVICES
3607 Manchaca Road
Austin, TX 78704
512-444-7219

Please release the following information:

___Initial Evaluation ___Re-evaluation ___Progress Notes ___Plan of Care

___History and Physical ___Discharge Summary ___Psychological Evaluation

___Other (Specify) _____

This information is necessary for the following purpose:

___ Continued Patient Care ___Insurance ___Personal Use ___Other (specify) _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the administrative office of KidWorks Therapy Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will not expire.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to assure treatment. I understand that with certain exceptions I may inspect or request copies of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the office manager at (512) 444-7219.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

This information has been disclosed to you from records protected by federal law (42 USCA Sec. 290-dd (2). Federal law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 USCA Sec. 290-dd(2).

NOTICE OF FINANCIAL RESPONSIBILITY

KidWorks Therapy Services

- KidWorks Therapy Services appreciates the confidence you have shown in choosing us to provide for your child's therapyneeds. The services that you have elected to participate in, implies a financial responsibility on your part. This responsibilityobligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of the services provided.

- You are responsible for the payment of any payment and co-payment amount due at the time of service and on receipt of a bill for any deductible/coinsurance as determined by your contract with your insurance carrier.
  - You may place a credit card on file with a release to bill your credit card on the 1st Friday of every month for your copayment/Coinsurance payments. If you elect to not place a credit card on file for copayment/coinsurance and your portion of the payment is not received before the end of your appointment a $10 late fee will be applied.
  - Please understand that many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you elect to continue therapy past your approved period, you will be responsible for your account balance in full. Failure todo so will result in your child being placed on hold until balance is paid in full or a payment plan has been created with the office management.
  - Please be aware that if your insurance carrier does not pay their balance within 60 days or recoups payment at a later date, you will be responsible for any amount not paid or recouped by your insurer.
  - Denied claims due to a termed policy will incur a balance given by your insurance plan. At this time you will be given the option to continue services at our fee for services rate of $105.00 for the hour or have your child placed back on the wait list until coverage is reinstated.

- Certain plans require authorization prior to beginning treatment. It is your responsibility to track the number of visits that your child is seen. If you exceed the number of authorized visits, you will be charged the regular rate for non-covered services. Please take into account any services you may have received at a different facility within the contract year with your insurance company.

- If payment due is not made within 90 days of the date of the first invoice the account will be turned over to Collections for management and collection of that account. Additional fees will be added.

- I authorize the release of any medical information necessary to process the insurance claim. I further authorize payment of medical benefits to Rebecca Pokluda, P.C. dba KidWorks Therapy Services.

- All Returned Checks will incur a $30 service fee and you will no longer be able to use checks as a form of payment.

- If KidWorks is unable to process your monthly credit card run a $10.00 service fee will incur. Payment must be made within 30days to avoid a $10.00 daily fee, which will incur until your balance is paid in full.

- Updates to your credit card must be provided to the front office by the 15th of each month. If a refund is requested a 4% charge will be added to your monthly balance

- KidWorks will provide an initial copy of your child's evaluations and billing statements. If any additional copies are requested a fee will incur.

- Parent conferences and Ard meetings are a non-covered insurance service that are offered under our fee for service rate of $105.00/Hr.

- All visits off site of clinic including school visits, home visits, or day care visits will incur a $10 service fee per service.

- Consultations including phone, text, and email over and above regular speech-language, occupational or physical therapy will incur a minimum of a $26.25 fee. Consultations will be billed in 15 minute increments and will be the responsibility of the parent/guardian. Insurance will not cover additionalconsultation over and above the regular treatment sessions.

- It is your responsibility to inform the office if there is an insurance change and provide the office with the new insurance card. Any treatment provided without the current insurance information on file prior to your child's appointment will be the client'sresponsibility.

- All questions regarding billing, insurance claims, or payments should only be directed to our billing specialist Crystal Castillo. Therapists do not have information regarding billing or charges, in order that their entire focus is on your childand family. Crystal Castillo will be happy to assist you and can be reached at: **512-444-7219 or 956-792-6794 between the hours of 8:00 am-5:30PM.**

- Please inform the office of any foreseen cancellations within 24 hours of your appointment time. All No-Show or Short Notice (less than 3 hour notice) appointments will incur a $50.00 fee. Please note that insurance companies do not reimburse forthese charges and they will be your responsibility. All fees will be strictly enforced during holidays when appointments have been confirmed and therapists' agree to see your child. Two "no show "cancellations, missing more than 50% of thescheduled treatment sessions, or habitual cancellations will result in the loss of a reserved treatment time slot.

FINANCIAL RESPONSIBILITY

I have read the above and hereby accept all responsibility for the evaluation and treatment costs incurred by my child. The undersigned certifies that he/she is the responsible party and accepts these terms. I certify that any and all information given by me to KWTS is correct to the best of my knowledge. I agree that a copy of this form shall be valid as the original and will not expire. The undersigned certifies that he/she is theresponsible party and accepts these terms.

_____ _____

Responsible Party Signature Date

_____ _____

Printed Name Printed Child's Name

Rebecca Pokluda, P.C.
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Authorization to Use Credit Card on File

Patient Name: _____

Name on Card: _____

Credit Card#: _____

□ Visa □ Mastercard □ Discover **Exp. Date:** _____ **CSV:**_____

I, _____, hereby authorize KidWorks Therapy Services to use the credit card provided to them to pay the deductible, copayments, allowable amounts and any unpaid services from Insurance. All cards will be run once a month to pay the balance in full. If KidWorks Therapy is unable to process my payment a $10.00 service fee will incur. Payment must be received within 30 days to avoid a $10.00 daily fee, which will incur until the balance is paid in full. If a refund is requested a 4% charge will be added to your monthly balance.

KidWorks Therapy Services will keep the credit card information confidential. I understand it is my responsibility to notify the office if I choose to cancel this agreement.

_____ _____
Signature Date

_____ _____
Clinic Manager Date