INTEGRATED AUTISM THERAPIES

5984 S Susquehanna, Murray, UT 84123 *(801) 885-1700*fax 1-801-905-3524

Today's Date:	**CLIENT INFORMATION**		**(Please Print)**
Last Name:	First:	Middle Initial: Age:	Date of Birth:
Address: City: State: Zip Code:	Sex: ☐ M ☐ F Name of Legal Guardian: Date of Legal Guardianship:		□ Legal Guardian Documentation
Email Address #1:		Email Address #2:	
Cell phone #1:	Contact:	Cell phone #2:	Contact:
Guardian #1:	Occupation:	Employer:	WK phone:
Guardian #2:	Occupation:	Employer:	WK phone:

Emergency Contact Person (other than guardians)

Name: Phone: Cell:
Relation:

Name: Phone: Cell:
Relation:

Name: Phone: Cell:
Relation:

PAYMENT RESPONSIBILITY & POLICY

Person Responsible for Bill: SS#:
Address (if different):
City:
State:
Zip Code:
Home Phone: Cell/Work Phone:
Employer:

Primary Insurance Provider:
Address/Claims:
City
State:
Zip Code:
Phone:
Issuer # Member ID: Group #:

Secondary Insurance Provider:
Address/Claims:
City
State:
Zip Code:
Phone:
Issuer # Member ID: Group #:

_____(Please Initial) I understand it is a courtesy to provide 48-hour notice (2 business days) in the event I need to cancel a consultation/meeting/ appointment. If I am unable to provide 24-hour (1 business day) notice for any cancellation, I understand I will be charged for my missed appointment (we *never* like to do this so *please* call - Thank you!).

_____(Please Initial) I understand that payment for all fees are payable to Integrated Autism Therapies, LLC (IAT) in behalf of practitioner or entity by cash or major credit card at the time services are rendered. We do not accept checks. I further understand that 21 % interest/annum for accounts 30 days past due. I further understand that payment is due at the time of, or previous to, services being rendered by cash, Visa, MasterCard, Discover, or a debit card. I understand IAT will never bill insurance nor file insurance claims for services not approved by my insurance providers. Failure to make payments in a timely manner can result in termination of services provided by IAT.

IF YOU WILL BE HAVING US SHIP ANYTHING TO YOU, OR PAYING FOR A CHILD OR SOMEONE ELSE WHEN YOU ARE NOT HERE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

I authorize Integrated Autism Therapies to charge the following credit card account for services received by Integrated Autism Therapies:
Please Sign: **X**
Credit Card Type: Last 4 Digits of the card to be used: (Please provide entire number to administration)
Expiration Date: CVV:

INTEGRATED AUTISM THERAPIES

5984 S Susquehanna, Murray, UT 84123 *(801) 885-1700*fax 1-801-905-3524

HIPAA NOTICE OF CLIENT PRIVACY PRACTICES

Your health information is private and protected by law. Your information will only be used or disclosed for the purpose of giving care, billing, or supporting day to day operations. You have the right to review your file. You may restrict all or part of your health information from being released, as allowable by law. If you request information to be transmitted electronically, please be advised that your private information may not be protected. Integrated Autism Therapies, LLC transmits from a secure, encrypted network server, however, we cannot guarantee that any information you receive from IAT or your therapy providers will be received through a secure network on your end. We will take every step necessary on our end to protect your privacy. A more detailed version of our privacy policy is available in your Parent Start Up Packet and upon request. If you choose to contact us or your therapy provider by electronic means, (ie: website, facebook, social media, text, email, etc), you understand that this is not a secured form of communication and your private health information may not be protected, and by contacting us via those means, you are waiving your Privacy Rights. Integrated Autism Therapies, LLC cannot guarantee your information remains protected during electronic communication.

_____ (Please Initial) *I have received* a *HIPAA NOTICE OF CLIENT PRIVACY PRACTICES (see above). I have had* a *chance to ask questions about privacy policies and I give* my *permission to this office to disclose* my *name and, or protected health information in accordance with such policies. I allow* my *health Information to be shared among practitioners, therapists, and providers at Integrated Autism Therapies, LLC, for the purpose of providing care and services*. *I further understand that* my *files will always remain the property* of *and in the care* of IAT. *I give permission for* my *picture to be kept on file for identification purposes.*

INFORMED CONSENT

_____ (Please Initial) By signing below, I am verifying that I have read this informed consent and I understand it. Additionally, I am here on this day and any subsequent visit, solely on my own behalf and not as an agent for any federal, state, or local agencies on a mission of entrapment or investigation and I also certify that I am signing my own true given, legal name and not an alias or false name. I am not a minor (under the age of 18), or I am the legal guardian of the client requesting services from Integrated Autism Therapies, LLC.

_____ (Please Initial) I understand that I have sought services provided through independent contractors, employees, and providers at Integrated Autism Therapies, LLC (IAT) for my personal wellness care or for my child or children who are minors or under my guardianship.

_____ (Please Initial) I understand that IAT may provide services from independent contractors and is exclusively an office-based practice. I recognize IAT is not affiliated with a local hospital or other special needs services. I further understand that IAT STRONGLY RECOMMENDS IN ADDITION TO ANY CARE RECEIVED AT IAT AND/OR AN INDEPENDENT CONTRACTOR THROUGH IAT, THAT I MAINTAIN A RELATIONSHIP WITH ONE OR MORE PHYSICIANS QUALIFIED TO CARE FOR MY MEDICAL CONDITION(S). For example, in the case of children IAT advises that I seek the advice of a MAPS pediatrician, DAN doctor, or Functional Medicine practitioner; if I have cardiovascular disease I consult with a cardiologist; if I have mental illness, I consult with a mental health specialist; and if I have cancer I consult with an oncologist, etc.

_____ (Please Initial) I understand that IAT and/or its employees, and/or its representatives make no representations, claims, or guarantees regarding the efficacy of a practitioner's practice, recommendations, treatments, procedures, or therapeutic services. I further acknowledge that I understand that any service and/or therapy I receive MAY alter, address, or decrease my pain, symptoms, or complaints, but also may have no effect at all.

_____(Please Initial) Integrated Autism Therapies (IAT) is unable to provide ABA, Occupational, or Speech therapy in conjunction with a client's therapy from a competing company or school due to liability and conflict of interest issues. You can share the results of the assessments we provide with other providers, but we can't work directly with the competing providers.

____ (Please Initial) CONFLICT RESOLUTION: By signing this informed consent I consent and agree to hold harmless, Integrated Autism Therapies, LLC (IAT), and/or their staff and/or employees, and/or associated entities from all professional and personal liability. I further understand and consent that that all services and/or therapies are patient and/or client directed therapies and I will direct my practitioner and/or staff to perform any therapy and/or service I receive at IAT. In doing so I, and any and all parties that may represent me or my estate, hold harmless Integrated Autism Therapies, LLC, the owners, therapies, providers, and/or staff and all other controlling or involved entities or manufacturers.

In the event I or my representative or heirs bring a legal case against IAT, I agree to be responsible for all legal costs and fees that may result from action(s) on my part or on the part of my representatives(s) against IAT or its representative(s). I agree that IAT shall be judged by the standards and principles of behavioral/holistic/alternative/complimentary health care. I agree to settle any claim, dispute, or disagreement I have with Integrated Autism Therapies, LLC and or Therapies, Providers, Owners, Practitioners and/or Staff in person. If this is not possible, then I agree to enter into good faith non-binding mediation with Peacemaking and Conflict Resolution Services (PMCRS) as mediator, or if

PMCRS is not available, I agree to meet with another mediator located in Salt Lake City, Utah or the surrounding area. If we are unable to settle via mediation, I further understand that any claim or dispute arising under or out of this Agreement shall be subject to binding arbitration pursuant to the Commercial Rules of the American Arbitration Association and conducted in the City of Salt Lake, Utah, or within the surrounding area. There shall be a single arbitrator selected by the American Arbitration Association. In no event shall either party be entitled to punitive damages. The parties shall split the cost of mediating and disputing equally. Any attorney's fees incurred during the mediation shall become a subject of the mediation and the parties will attempt to resolve attorney's fees during the mediation. The costs of binding arbitration shall be split between the parties equally and the arbitrator. Each party is responsible for their own attorney fees for arbitration.

I further understand and consent that I have the right to have this consent reviewed by my lawyer before accepting any behavioral, wellness care, and/or nutritional services from Integrated Autism Therapies, LLC. Although IAT and/or the staff and/or therapists will not be able to provide any professional services to clients and or patients who choose not to sign, we will provide any medical records we have in our possession to you so that you can select the healthcare practitioner of your choice for your continued care.

_____ (Please Initial) SEVERABILITY: If any term, provision or condition of this Agreement, or any application thereof, should be held by a court of competent jurisdiction to be invalid, void, or unenforceable, all provisions and conditions of this Agreement and all applications thereof not held invalid, void or unenforceable, shall continue in full force and effect and shall in no way be affected, impaired or invalidated thereby. By entering my signature below, I am acknowledging that I understand all terms, verbiage (language) and concepts herein.

I hereby consent to and authorize the above understandings of this Informed Consent for me and/or my child(ren). I have executed this agreement freely and willingly.

Client Name (Please Print) _____ Signature _____ Date: _____

Parent or Guardian signature if under 18: _____ Date: _____

Witness: _____ _____ Date: _____

Fee Acknowledgment

Functional medicine, The Listening Program (TLP), integrative medicine, holistic medicine, mild HBOT, behavioral, wellness care, REHAB/THERAPY, and/or nutrition services, along with some additional services provided by Integrated Autism Therapies, are all science-based. However, many may be considered a form of alternative medicine or complementary by some insurance providers. Though our therapists, coaches, and practitioners are licensed, certified and board certified, certain insurance providers do not, or may not, recognize them as necessary medicine or therapies. These services (e.g. function health and lifestyle coaching, functional nutrition, functional fitness, The Listening Program, HBOT, etc.) are considered complimentary services and therefore are not covered by health insurance in most cases. Even some traditional ASD services may not be covered by certain insurance providers.

Integrated Autism Therapies, LLC (IAT) is associated with certain insurance companies. However, not all insurance companies share the same philosophies, which means insurance companies may not feel obligated to pay for services you may opt to receive at Integrated Autism Therapies (TLP, Functional Medicine Health Coaching, Occupational Therapy, HBOT). We require payment at time of service or can work out a payment plan for services not covered by your insurance carrier. If you choose, we can provide a receipt showing that you paid out of pocket and what the visit was for. WE WILL NOT, however, communicate in any way with insurance companies or Health Saving Plans that do not cover

our services. This is not a guarantee that those services will be paid for by your insurance company. Some of the services provided at IAT and/or by Independent Contractors (Practitioners) do not have medical billing codes.

For clients who have access to a Health Savings Account, some of your appointments may qualify for use with that credit or debit card. Please check with your plan to see what they will cover prior to using your Health Savings Account for your visit. If your plan covers those services and you wish to put it on your Health Savings Account, please inform IAT management prior to the beginning of your services so that they prepare your receipt accordingly. Even then, this does not guarantee that your Health Savings Account will accept your claim.

The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company for services that they do not cover. or that your insurance company has not pre-approved or covered you for. Any follow up letters from your insurance to us regarding services we offer that they do not cover will be thrown away. If we receive a check from your insurance company for services they did not authorize or do not cover, we will not cash it, but instead return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company unless they are discussing services covered by your insurance provider or that you have been pre-approved for.

We will be happy to work with you regarding a payment plan for the services you would like to receive but your insurance company will not cover.

We accept the following forms of payment:

Master Card, Visa, Discover, Debit, and Cash

By signing below, I hereby acknowledge receipt and understand of IAT fee policy:

X _____ _____ _____

Print Name | Client Signature | Date Signed