Patient's Name: ____

DOB: ______________ M ___ F ___ Preferred Name __________________________

Address:____

____

Parents/Guardians Contact Information:

Primary Contact	**Alternate Contact**
Name: ___________________________	Name:______________________________
Relation to Child: ____________________	Relation to Child: _____________________
Phone Number: ______________________	Phone Number: ______________________
Can we text this number? Yes___ No___	Can we text this number? Yes___ No___

Emergency Contact Name, Number & relation to child:

____

Is Mealtime Connections authorized to leave detailed phone messages or text messages on all phone numbers supplied to us on this page? Yes___ No___

Would you like TEXT reminders for your child's appointments? Yes___ No___

Text reminders will be sent to the primary phone number given unless otherwise specified.

Would you like EMAIL reminders for your child's appointments? Yes___ No___

Email address: ____

Email or text reminders may contain patient or clinic information such as, but not limited to: patient first name, type of appointment, & clinic location.

I authorize the release of any information needed to file a claim to the insurance company. I authorize payment of medical benefits to: Mealtime Connections, LLC.

____

Signature of parent/guardian   Date

Child’s name: ____ Date of birth: _____________

Please only release or request medical documentation relevant to my child’s therapeutic treatment from the following:

Primary Care Physician Name: ____

Other Name/Title: ____

Other Name/Title: ____

Other Name/Title: ____

Other Name/Title: ____

Other Name/Title: ____

Is Mealtime Connections authorized to leave detailed phone messages on all phone numbers supplied to us on this page? Yes___ No___

Primary Insurance Carrier: ____
Member ID #: _______________________________________Policy/Group # ______________
Insured’s Name: ____ Date of Birth:___________

Secondary Insurance Carrier: ____
Member ID #____Policy/Group #: ______________
Insured’s Name: ____ Date of Birth: ___________

My signature authorizes Mealtime Connections LLC to release and/or request medical and treatment information regarding my child to and/or from the providers and organizations listed above.

Signature of parent/guardian: ___________________________________ Date: ______________

Print name of parent/guardian: ____

1. **Medical and Therapy Consent:** The undersigned consents to therapy services. The client acknowledges that the consent of Mealtime Connections to use items, including food items, is a condition of admission. The undersigned also consents to observation and/or demonstration of the client during therapy treatments for the purpose of education of physicians, therapy students, and any other proper student or technician whose presence is deemed appropriate by the professional staff or referring physician. Permission from the parent or caregiver will be obtained prior to any observation session. Mealtime Connections personnel will provide care based on state licensure and national board standards.
2. **Release of Patient Information:** Demographic information, including client's name, age, address, sex, payer status, general condition, and information of a clinical nature is collected by Mealtime Connections. This information is used for general purposes of Mealtime Connections as described in the Notice of Privacy Practices. Mealtime Connections may disclose non-identifying information for the advancement of medical science, education, research, the preservation of the public health, or in response to legal or statutory requirements.
3. **Personal Valuables/Personal Property:** Mealtime Connections shall not be liable for loss or damage to any personal property during their treatment at Mealtime Connections. Belongings that may pose a safety hazard or disrupt Mealtime Connections activities are not permitted and may be cause for revocation of services.
4. **Allergy Policy:** We are aware that many of our clients have food allergies and intolerances. Please notify your therapists of all food allergies and intolerances. All foods utilized in therapy sessions must be reviewed and approved by the client's caregiver. The Mealtime Connections clinic does not utilize products with peanuts; however there is the possibility of allergen cross-contamination. Mealtime Connections shall not be held liable for any reactions to allergens.
5. **Infectious Disease Policy:** Therapists will not see clients with communicable diseases or contagious illnesses such as fever, vomiting and diarrhea due to illness with the last 24 hours or an active cough. Clients must notify therapists as soon as they find out they have a communicable disease or contagious illness. Clients may not come to the office if they are contagious, or if any sibling or caretaker accompanying them is contagious. Therapists will not enter a client's home if the client, or any member of the client's household is contagious.
6. **Immunization Policy:** By signing below, you are confirming that your child's immunizations are current.

The undersigned has read and understands the Conditions of Treatment and has received a copy of the Notice of Privacy Practices. These Conditions of Treatment may not be altered or amended. Any such changes will have no force and effect.

____ _________________________

Child's Name Date of Birth

____ _________________________

Signature of parent/guardian Date

It is our ultimate goal and intention at Mealtime Connections, LLC to provide you and your family with the highest quality of care while addressing your family's individual needs. We view every family as an extension of our own and strive to empower and serve each member as an individual.

Client Rights
It is you and your child/ward's right:

1. To be treated with respect for personal dignity and need for privacy regardless of race, color, religion, sex, age, physical or mental limitations or national origin.
2. To participate in decisions involving treatment or the plan of care.
3. To reasonably access therapy services and information regarding financial charges for which you will be responsible.
4. To express an inquiry/complaint or file an appeal and expect an answer to this inquiry/complaint or appeal within a reasonable period of time.

Privacy Practices
Mealtime Connections, LLC is required by law to maintain the privacy of you or your child/ward's protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy practices that are outlined in this notice. By signing consent, you are hereby notified that you or your child/ward's:

1. Health information may be disclosed to other health care professionals for the purpose of providing treatment.
2. Health information may be used to seek payment from your health plan or other sources of coverage.
3. Health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government mandated reporting.
4. Health information may be disclosed to public health agencies as required by law.
5. Health information may not be used without written authorization for any purpose other than those listed above. Please be aware that your decision to deny authorization will not undo or affect any use or disclosure of information that occurred before you notified Mealtime Connections, LLC of your decision to revoke authorization.

I have read the above information and am aware/notified of my personal rights and Mealtime Connections, LLC privacy practices in their entirety.

____ ______________________
Child's Name Date of Birth

____ ______________________
Signature of parent/guardian Date

1. As a courtesy to you, Mealtime Connections LLC, will bill your services to your insurance company, provided that you submit all the necessary information to us. You are responsible for any portion of your charges remaining unpaid by your insurance company.

2. It is your responsibility to be aware of any exclusions or limitations, benefits, copayments and deductibles outlined in your insurance plan. We will attempt to pre authorize visits as appropriate please note that preauthorization is not a guarantee of payment.

3. All copays, co insurance, deductibles or any balance you may have are due at the time services are provided.

4. You are responsible for notifying Mealtime Connections of all insurance changes. If your insurance changes or terminates, Mealtime Connections must be aware before charges go against the account. If notification is not received prior to treatment, you will be personally responsible for all treatment charges.

5. It is your responsibility to complete and update any Coordination of Benefits (COB) information with your insurance company as requested. Any claims denied for COB issues will be your responsibility to pay.

6. **Financial Agreement:** The undersigned agrees, whether signing as client or parent or legal guardian of the client, and whether or not he is insured or is a member of a health maintenance organization, that in consideration of the services to be rendered to the client, he hereby individually obligates himself to pay the account of Mealtime Connections in accordance with regular rates and terms of Mealtime Connections. A $25 late fee will be added monthly to accounts that are unpaid after sixty days. Should the account be referred to collection, the undersigned shall pay reasonable collection expenses, including attorney's fees and costs.

7. **Late Cancellation/No Shows:** Please notify Mealtime Connections of appointment cancellations at least 24 hours prior to your scheduled appointment time. Any cancellation that is given with less than 24 hours notice is considered a late cancellation. Late cancellations and "No Shows" are subject to a $30 late cancellation/"no show" fee. Mealtime Connections LLC retains the right to discontinue services after 2 late cancellations/"No Shows" and the client's referring physician and/or support coordinator will be notified.

______________________________ ______________________

Child's Name Date of Birth

______________________________ ______________________

Signature of parent/guardian Date