PATHWAYS PEDIATRIC THERAPIES

1110 Carrol Rd Paragould, AR 72450 (870) 897-2372 (phone) (870) 236-2529 (fax)

Child's Information

Referring Physician	Today's Date
Child's Name	Date of Birth
Child's Social Security #	❑ Male ❑ Female

Reason for Referral

❑ Applied Behavioral Analysis (ABA) Therapy, explain ______________________
❑ Developmental Therapy, explain ____________________________________
❑ Occupational Therapy, explain ______________________________________
❑ Physical Therapy, explain ____
❑ Speech Therapy, explain ____

Medical Diagnosis ❑ Autism ❑ Down Syndrome ❑ Other ___________________________	Allergies (Food, Seasonal, etc.)
Medications	Surgeries

Child lives with (relationship to child) _____________________________________
Legal Guardian ____
Physical Address ____
Mailing Address ____

***If you are not a biological parent of this child, please provide some form of legal documentation showing guardianship**

Assistive Devices

❑ Glasses ❑Wheelchair ❑ Walker ❑Hearing Aids
❑ Orthotics ❑Shoe Inserts ❑ Other

Illnesses/Sicknesses/Etc.

❑ Ear Infections ❑ Heart Problems ❑ Trach
❑ Congenital Defects ❑ Seizures ❑ Feeding deficits
❑ Swallowing Deficits ❑ Behavior ❑ Meningitis

Prenatal

❑ Foster/Adopted – Limited Knowledge

❑ Full-term ❑ Premature

Weeks: _______ Birth Weight: ________ Birth Height: _______

❑ Vaginal Delivery ❑ Planned C-Section

❑ Uncomplicated ❑ Complications ___________________________________

Exposure during pregnancy to:

❑ Infection/Illness____________________ ❑ Medications ❑ Drug ❑ Alcohol

Family History

❑ Developmental Delays ❑ Autism ❑ Mental Illness

❑ Speech/Language Disorder ❑ Other Genetic Disorder _________________

Last Hearing Screening was completed on ___________

❑ Passed ❑ Failed

During Infancy

❑ Fussy ❑ Irritable ❑ Calm

❑ Spit up often ❑ Babbled ❑ Alert

❑ Good sleep patterns ❑ Poor sleep patterns ❑ Active

❑ Enjoyed being held ❑ Resisted being held ❑ Floppy

❑ Poor/Picky Eater ❑ Quiet ❑ Easy baby

Social/Sensory

❑ Plays appropriately with toys

❑ Has difficulty concentrating

❑ Keeps up with peers academically

❑ Appears awkward/clumsy

❑ Takes turns

❑ Seems lazy/lethargic

❑ Shies away from new activities

❑ Avoids eye contact

❑ Uses pacifier (past/current)

❑ Interacts with adults appropriately

❑ Gets easily frustrated

❑ Seems impulsive

❑ Reacts to loud noises/bright lights

❑ Has sensitivities to textures (food, tags, bathing, clothing, etc.), explain______________

❑ Prefers certain types of clothing

❑ Has difficulty sitting still

❑ Likes to crash into things

❑ Engages in odd behavior _____________

❑ Dislikes change/transitions

❑ Has inappropriate fears/avoidances

❑ Avoids sensory input ________________

❑ Seeks sensory input ________________

❑ Other_____________________________

Contact Information

<table>
<tr><td colspan="2">Primary Contact/Responsible party/Guarantor Name</td></tr>
<tr><td>Phone Number</td><td>Email</td></tr>
<tr><td>ID</td><td>Driver’s License</td></tr>
<tr><td colspan="2">Address</td></tr>
<tr><td colspan="2">Relationship to Child</td></tr>
<tr><td colspan="2">Please mark the following for this contact
❑ Legal guardian
❑ Contact for appointments
❑ Discuss medical information
❑ Pick up from appointments</td></tr>
</table>

<table>
<tr><td colspan="2">Secondary Contact Name</td></tr>
<tr><td>Phone Number</td><td>Email</td></tr>
<tr><td>ID</td><td>Driver’s License</td></tr>
<tr><td colspan="2">Address</td></tr>
<tr><td colspan="2">Relationship to Child</td></tr>
<tr><td colspan="2">Please mark the following for this contact
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❑ Contact for appointments
❑ Discuss medical information
❑ Pick up from appointments</td></tr>
</table>

Emergency Contact Name	
Phone Number	Email
ID	Driver’s License
Address	
Relationship to Child	
Please mark the following for this contact ❑ Legal guardian ❑ Contact for appointments ❑ Discuss medical information ❑ Pick up from appointments	

Insurance Information

<table>
<tr><td colspan="2">Please be sure to fill out ALL insurance information. This will ensure accurate billing.
Notify Pathways of any changes to insurance/payment type.
Bring a copy of insurance cards or bring the originals for copying.</td></tr>
<tr><td>Primary Insurance Company</td><td>Policy #/Member ID</td></tr>
<tr><td>Insured Person</td><td>Group #</td></tr>
<tr><td>Insured’s Date of Birth</td><td>Relationship to Insured
❏ Self ❏ Child/Dependent</td></tr>
<tr><td>Insurance Company Address</td><td>Insurance Company Phone #</td></tr>
<tr><td>Secondary Insurance Company</td><td>Policy #/Member ID</td></tr>
<tr><td>Insured Person</td><td>Group #</td></tr>
<tr><td>Insured’s Date of Birth</td><td>Relationship to Insured
❏ Self ❏ Child/Dependent</td></tr>
<tr><td>Insurance Company Address</td><td>Insurance Company Phone #</td></tr>
<tr><td>Guarantor Name</td><td>Date of Birth</td></tr>
<tr><td>Phone Number</td><td>Group #</td></tr>
<tr><td>Insured’s Date of Birth</td><td>Mailing Address</td></tr>
<tr><td>Employer</td><td>Employer Phone Number</td></tr>
<tr><td colspan="2">I certify that the information in this intake packet is true and accurate. I authorize the release of any medical information necessary to process a claim and/or treatment. I acknowledge that I am responsible for payment on any balance not covered by insurance.</td></tr>
<tr><td>Authorized Person Signature</td><td>Date of Signature</td></tr>
</table>

Occupational Therapy

Activities of Daily Living (ADLs) & Instrumental Activities of Daily Living (IADLs) *Please mark an independence level for each task that is applicable to your child*			
Task	**Can do independently**	**Can do with some help**	**Cannot do**
Feeding self with spoon or fork	☐	☐	☐
Drinking from cup edge	☐	☐	☐
Writing name	☐	☐	☐
Cutting with scissors	☐	☐	☐
Catching a ball	☐	☐	☐
Toilet training	☐	☐	☐
Taking off shirt	☐	☐	☐
Putting on shirt	☐	☐	☐
Taking off pants	☐	☐	☐
Putting on pants	☐	☐	☐
Taking off socks	☐	☐	☐
Putting on socks	☐	☐	☐
Brushing teeth	☐	☐	☐
Brushing hair	☐	☐	☐
Washing face	☐	☐	☐
Washing hands	☐	☐	☐
Bathing	☐	☐	☐
Buttoning buttons	☐	☐	☐
Unbuttoning buttons	☐	☐	☐
Snapping snaps	☐	☐	☐
Unsnapping snaps	☐	☐	☐
Tying shoes	☐	☐	☐
Other daily living concerns (including self-care, play, and school-based):			

Physical Therapy

Please mark an independence level for each task that is applicable to your child			
Task	**Can do independently**	**Can do with some help**	**Cannot do**
Fully rolling over left and right	☐	☐	☐
Sitting without help or support	☐	☐	☐
Crawling on all fours without scooting	☐	☐	☐
Standing up from floor keeping balance	☐	☐	☐
Walking without support	☐	☐	☐
Climbing stair without support using one foot on each step	☐	☐	☐
Climbing on/off something higher than 7 inches	☐	☐	☐
Running with control with both feet leaving the ground (flight phase)	☐	☐	☐
Jumping up with both feet leaving the floor	☐	☐	☐
Skipping, alternating feet	☐	☐	☐
Ride a bike using the pedals	☐	☐	☐
Sit on a bike and push with feet	☐	☐	☐
Other daily living concerns			

Speech Therapy

Language Concerns

❑ Following directions
❑ Poor understanding
❑ Screams to communicate
❑ No attempt to communicate
❑ Nonverbal
❑ Uses gestures more than words
❑ Limited number of words
❑ Uses some phrases
❑ Poor sentence formation during speech
❑ Expressing wants/needs
❑ Asking questions
❑ Answering questions
❑ Comprehending stories
❑ Age-appropriate behavior/socialization with peers
❑ Reading
❑ Writing
❑ Social language skills (ex. greeting others, reading social cues, reading other's emotions, turn-taking during conversation, carrying a conversation, etc.)

Explain____

Speech Concerns

❑ Difficult to understand
❑ Gets frustrated with his/her speech
❑ Has trouble saying consonant sounds
❑ Inappropriate repetition of syllables/words/phrases/sentences (stuttering)

Explain____

I understand ______ % of my child's speech
Unfamiliar listeners understand ______ % of my child's speech

Swallowing Concerns

❑ Gets choked on food ❑ Had a swallow study on_______________________
❑ Gets choked on drinks ❑ Has a diagnosis of a swallowing disorder

Explain____

Notice of Privacy Practices

This information describes how medical information about you may be used and disclosed, as well as, how you can get access to this information. Please review it carefully.

Pathways Pediatric Therapies is dedicated to protecting your medical information. A federal regulation, known as the "HIPAA Privacy Rule," requires that we provide detailed notice in writing of our privacy practices. This notice describes how we may use and disclose your protected health information to carry out treatment, for payment or health care operations, and for the purposes that are permitted or required by the law. It also describes your rights to access and control you "protected health information" (PHI). Your PHI refers to any of your written and oral health information, including demographic data that can be used to identify you. This is health information that is created or received by your provider, and that relates to your past, present, or future physical or mental health condition.

HOW WE MAY USE AND DISCLOSE YOUR PHI

1. Treatment, Payment, and Health Care Operations. As described below, we will use or disclose your PHI for treatment, payment, or health care operations. The examples below do not list every possible use or disclosure in a category.
   - Treatment: We may use and disclose PHI about you to provide, coordinate, or manage your health care and related services. We may consult with other health car providers regarding your treatment and coordinate and manage your health care with others. For example, we may use and disclose PHI when you need a prescription, referral, or other health care services. We may also disclose PHI about you when referring you to another health care provider. For example, if you are referred to a specialist, we may disclose PHI to the specialist regarding your symptoms. We may also disclose PHI about you for the treatment of another health care provider. For example, we may send a report about your care from us to another physician so that the other physician may treat you.
   - Payment: We may use and disclose your PHI so that we can bill and collect payment for the treatment and services provided to you. For example, we may send your insurance company a bill for services or release certain medical information to your health insurance company so that it can determine whether your treatment is covered under the terms of your health insurance policy. We also may use and disclose PHI for billing, claims management, and collection activities. We may also disclose Phi to another health care provider or to a company or health plan required to comply with the HIPAA Privacy Rule for the payment activities of that health care provider, company, or health plan. For example, we may allow a health insurance company to review PHI relating to their enrollees to determine the insurance benefits to be paid for the enrollee's care.
   - Health Care Operations: We may use and disclose PHI in performing certain business activities which are called health care operations. Some examples of these operations include our business, accounting, and management activities. These health care operations include our business, accounting, and management activities. These health care operations also may include quality assurance,

utilization review, and internal auditing, such as reviewing and evaluating the skills, qualifications, ad performance of health care providers taking care of you and our other patients and providing training programs to help students develop or improve their skills. If another health care provider, company, or health plan that is required to comply with the HIPAA Privacy Rules has or once had a relationship with you, we may disclose PHI about you for certain health care operations of that health care provider or company. For example, such health care operations may include assisting with legal compliance activities of that health care provider or company.

2. Communications To You from Our Office. We may use or disclose medical information to contact you as a reminder that you have an appointment for treatment or other medical care, to tell you about or recommend possible treatment options or alternatives that may be of interest to you, or to inform you about health-related benefits or services that may be of interest to you.

3. Communication To Family, Friends If You Agree or Do Not Object, Disaster Relief. We may disclose PHI to your relatives, close friends or any other person identified by you if the PHI is directly related to that person's involvement in your care or payment for your care. Generally, except in emergency situations, we will inform you of our intended action prior to making any such uses and disclosures and will, at that time, offer you the opportunities to object. However, if you are not present or are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. WE also may use and disclose your health information for the purpose of locating and notifying your relatives of close personal friends of your location, general condition, or death, and to organizations that are involved in those tasks during disaster situations. We will provide you with an opportunity to agree or object to such disclosures whenever it is practical to do in a disaster relief situation.

4. Other Uses and Disclosures Authorized by the HIPAA Privacy Rule. We may use and disclose PHI about you in the following circumstances, if we comply with certain legal conditions set forth in the HIPAA Privacy Rule.
   - Required By Law. We may use or disclose PHI as required by federal, state, or local law if the disclosure complies with the law and is limited to the requirements of the law.
   - Public Health Activities. We may disclose PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including to:
     - Prevent or control disease, injury, or disability or report disease, injury, birth, or death
     - Report child abuse or neglect
     - Report information regarding to the qualify, safety, or effectiveness of products or activities regulated by the Federal Food and Drug Administration
     - Notify a person who may have been exposed to a communicable disease to control who may be at risk of contracting or spreading the disease; or
     - Report to employers, under limited circumstances, information related to primarily workplace injuries or illness or workplace medical surveillance
     - Report to schools, under limited circumstances, proof of immunization

- Abuse, Neglect, or Domestic Violence. We may disclose PHI to proper government authorities if we reasonable believe that a patient has been a victim of domestic violence, abuse, or neglect.
- Health Oversight. We may disclose PHI to a health oversight agency for oversight activities including, for example, audits, investigations, inspections, licensure, and disciplinary activities and other activities conducted by health oversight agencies to monitor the health care system, government health care programs, and compliance with certain laws.
- Legal Proceedings. We may disclose PHI as expressly required by a court or administrative tribunal order or in compliance with state law in response to subpoenas, discovery requests or other legal processes when we receive satisfactory assurances that efforts have been made to advice you of the request or to obtain an order protecting the information requested.
- Law Enforcement. We may disclose PHI to law enforcement officials under certain specific conditions where the disclosure is:
  - About a suspected crime victim if the person agrees or, under limited circumstances, are unable to obtain the persons' agreement because of incapacity or emergency
  - To alert law enforcement of a death that we suspect was the result of criminal conduct
  - In response to authorized legal process or required by the law
  - To identify or locate a suspect, fugitive, material witness, or missing person
  - About a crime or suspected crime committed on our premises, or
  - In response to a medical emergency not occurring on our premises, if necessary to report a crime.
- Coroners, Medical Examiner or Funeral Directors. We may disclose PHI regarding a deceased patient to a coroner, medical examiner, or funeral director so that they may carry out their jobs. We also may disclose such information to a funeral director in reasonable anticipation of a patient's death.
- Organ Donation. We may disclose PHI to organizations that help procedure, locate, and transplant organs to facilitate organ, eye, or tissue donation and transplantation.
- Threat to Health or Safety. In limited circumstances, we may disclose PHI when we have a good faith belief that the disclosure is necessary to prevent a serious and imminent threat to the health or safety of a person or to the public.
- Specialized Government Functions. We may disclose PHI for certain specialized government functions, such as military and veteran activities, national security and intelligence activities, protective services for the president and others, medical suitability determinations, and for certain correctional institutions or in other law enforcement custodial purposes.
- Compliance Review. We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule.
- Research. For research purposes under certain limited circumstances of research projects that have been evaluated and approved through and approval process that considers patients' need for privacy, we must obtain a written authorization to use and disclose PHI about you for research purposes except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule to ensure the privacy of PHI.
- Data Breach Notification Purposes. We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information if that happens.

5. Emergencies. We may use and disclose your PHI in emergency treatment situations in compliance with applicable laws and regulations.

6. You Written Authorization is Required for Other Uses and Disclosures. The following uses and disclosures of your PHI will be made only with your written authorization:
   - Psychotherapy Notes. Certain uses or disclosure of Psychotherapy Notes,
   - Marketing. Uses and disclosures of PHI for marketing purposes,
   - Sale. Uses and disclosures that constitute a sale of your PHI, and
   - All Other Uses; Revocation. All other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you have authorized us to use or disclose PHI about you, you may revoke your authorization at any time, in writing, except to the extent we have taken action based on the authorization.

YOUR RIGHTS REGARIDNG YOUR PROTECTED HEALTH INFORMATION

The HIPAA Privacy Rules gives you several rights regarding your PHI These rights include:

1. Right to Request Restrictions. Out of Pocket Payments. Unless otherwise required by the law, we are required to agree to your request to restrict use and disclosure of your PHI to a health plan for payment or health care operations when the information you wish to restrict pertains solely to a health care item or services for which you have paid us "out-of-pocket" in full. (In other words, you have requested that we not bill your health insurance plan and have paid us yourself.) Other Requests. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations, or that we disclose to those who may be involved in your care or payment for your care. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. While we will consider your request for a restriction, we are not required to agree to it. If we do agree to your request, we will comply with your request except as required by law or for emergency treatment. To request restrictions, you must make your request in writing on our Request for Additional Privacy Form to the Clinic Manager at each of the Clinic locations where additional privacy is requested.

2. Right to Receive Confidential Communications. You have the right to request that you receive communications regarding your PHI in a certain manner or at a certain location. For example, you may request that we contact you at home, rather than at work. You must make your request in writing by submitting our Request for Alternative Communication Form specifying how you would like to be contacted (for example, by regular mail to your post office box and not your home) to the Clinic Manager at each of the locations where alternative communications are requested. We will accommodate all reasonable requests.

3. Right to Inspect and Copy. You have the right to inspect and receive a copy of your PHI contained in records we maintain that may be used to make decisions about your care. These records usually include your medical and billing records but do not include psychotherapy notes; information gathered or prepared for a civil, criminal, or administrative proceeding; or PHI that is subject to law that prohibits access. To inspect and copy your PHI, please contact our Privacy Officer at the address listed on the last page of this Notice. If you request a copy of PHI about you, we may charge you a reasonable fee for the copying, postage, labor, and supplies used in meeting your request. We may deny your request to inspect and copy PHI only under limited circumstances, and in some cases, a denial of access may be reviewable.

4. Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in and electronic format, you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. A request to transmit your record to another individual or entity must be in writing, signed by you, and must clearly identify the designated person and where to the PHI. We will make every effort to provide access to your PHI in the form or format you request if it is readily producible in the form or format you request. If not readily producible, your record will be provided in a readable electronic format. We may charge you a reasonable cost-based fee for the labor and supplies associated with transmitting or providing an electronic copy of the medical record.

5. Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information for as long as such information is kept by or for us. You must submit your request to amend in writing to our Privacy Officer and give us a reason for your request. We may deny your request in certain cases. If your request is denied, you may submit a written statement disagreeing with the denial, which we will keep on file and distribute with all future disclosures of the information to which it relates.

6. Right to Receive an Accounting of Disclosures. You have the right to request a list of certain disclosures of PHI made by us during a specified period of up to six years prior to the request, except disclosures for treatment, payment, or health care operations; made to you; to persons involved in your care or for the purpose of notifying your family or friends of your whereabouts; for national security or intelligence purposes; made pursuant to your written authorization; incidental to another permissible use or disclosure; and for certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes). If you wish to make such a request, please contact our Privacy Officer. The first accounting that you request in a 12-month period will be free, but we may charge you for our reasonable costs of providing additional lists in the same 12-month period. We will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred.

7. Right to Get Notice of a Breach. If there is a breach of any of your unsecured PHI, you the right to be notified.

8. Right to a Paper Copy of this Notice. You have a right to receive a paper copy of this Notice at any time. You are entitled to a paper copy of this Notice even if you have previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact our Privacy Officer.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, of the Secretary of the United States, Department of Health and Human Services. To file a complaint with our office, please contact our Privacy Officer. We will not take action against you or retaliate against you in any way for filing a complaint.

QUESTIONS

If you have any questions or need additional information about this Notice, please contact our Privacy Officer.

PRIVACY OFFICER

You may contact our Privacy Officer at the following address and phone number:

Privacy Officer – Pathways Pediatric Therapies
1110 Carroll Road, Paragould, Arkansas 72450
(870) 897-2372

Authorization & Privacy Notice

<table>
<tr><td colspan="2">I authorize Pathways Pediatric Therapies to evaluate and/or treat my child in the following areas:

❑ Applied Behavioral Analysis (ABA) Therapy

❑ Developmental Therapy

❑ Occupational Therapy

❑ Physical Therapy

❑ Speech Therapy</td></tr>
<tr><td colspan="2">By signing, I agree that I have reviewed the Notice of Privacy Practice given to me by Pathways Pediatric Therapies. I agree that these services are not being provided to this child by another agency or individual not employed by Pathways Pediatric Therapies. I also agree to allow Pathways Pediatric Therapies to bill my insurance and/or Medicaid or myself for services rendered. I also may revoke this authorization at any time, in writing.</td></tr>
<tr><td>Authorized Person Signature</td><td>Date of Signature</td></tr>
</table>

Release of Information

I consent for Pathways Pediatric Therapies to release my protected health information to ___________________________ and I consent for the listed party to release my protected health information to Pathways Pediatric Therapies. The above parties may release my entire Medical Record, including but not limited to, patient histories, office notes (except psychotherapy notes), test results, referrals, consults, insurance records, and records received from other health care providers. I understand that the information obtained will be used to complete my therapy, medical records, history, and to coordinate services and care between providers. I voluntarily allow the release of the above information. I have not been threatened or forced to sign this consent. I also understand that I may revoke this consent to release information at any time, in writing.	
Authorized Person Signature	Date of Signature

Picture/Audio/Video Consent

<table>
<tr><td colspan="2">I authorize for Pathways Pediatric Therapies to complete the following:

❑ Take pictures of client to send to caregiver over phone
❑ Take video/audio recordings of client to send to caregiver over phone

❑ Take pictures of client to post on Pathways’ social media

❑ Take video/audio recordings of client to post on Pathways’ social media
[I understand that they may remain on social media even if client is discharged. It is Pathways’ intent to represent client in a positive, respectful way- each picture/recording is to be individually approved by caregiver before posting.]

❑ Take pictures/video/audio recordings of client to share with treating therapists or supervisor for training, supervision, and/or educational purposes- to be destroyed after served its purpose</td></tr>
<tr><td colspan="2">I also understand that I may revoke this authorization at any time, in writing.</td></tr>
<tr><td>Authorized Person Signature</td><td>Date of Signature</td></tr>
</table>

Attendance Policy

The primary focus at Pathways Pediatric Therapies is to help the patients achieve his/her goals for therapy. Consistent therapy attendance is critical to establish a positive treatment routine, achieve goals and obtain effective outcomes for your child.

By signing the attendance policy agreement form, you are indicating that you understand the attendance policy and the consequences of not keeping your appointments. We anticipate that you will adhere to the following:

Tardiness

- Therapists often are not able to wait more than 15 minutes for a late client. Please notify your therapist as soon as you know you are going to be late. Because of scheduling constraints, late arrivals may not be able to be seen, and if seen, the session will end at the regular scheduled time.
- After 3 late arrivals to appointments within a 1-month time frame, you will be billed for therapist's lost time, per therapy, per 3 late arrivals.
- If client is more than 30 minutes late for appointment, and you have failed to notify us, this will be considered a "no-show". Each No-Show will result in a $75 fee per therapy, per occurrence.

Absences/ No-Shows

- Missing 3, or greater than 25% of scheduled appointments, within a 3-month period, without any effort of rescheduling, will result in therapy being suspended, client being removed from the schedule and client's primary care physician being notified. If you must cancel the appointment due to illness or emergency, contact the office as soon as possible. Family emergencies will be taken into consideration.
- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE, or a $75 fee will be charged per therapy, per occurrence.
- Charges will be waived for absence due to illness, safety concerns, medical conditions, medical or family emergencies. You will not be charged for sessions that are cancelled by your therapist. We will always be understanding where possible, so we urge families to do the same by calling and letting us know about exceptional circumstances. We will do what we can to work with you and your schedule.
- Client will not be penalized for weather-related absences. However, a courtesy call is required if client will not be attending. If the clinic is closed, a staff member will contact you.
- Please notify us 2 weeks in advance of extended absences such as vacation.
- If client's therapist must cancel for any reason, client will be given the option to see another therapist if available, or to reschedule.

Please note fees are the responsibility of the client and will be sent out via monthly invoice. These fees will not be charged to insurance.

- 3 late appointments within a 1-month time frame, will result in a fee.
- No-Call No-Show will result in a $75.00 fee per therapy, per occurrence.
- Less than 24-hour notice will result in a $75.00 fee per therapy, per occurrence.

Again, we understand things happen, and we will do our best to work with you and be considerate of special circumstances. We just ask that clients are considerate of your therapist's time as well.

To avoid being billed these fees, should you not be able to attend a scheduled appointment, please notify your child's therapist. If you cannot reach your child's therapist personally, please call or text our office phone at (870)897-2372. You may also reach us by email at office@pathwayspediatrictherapies.com Facebook messenger or in person at our front office.

Attendance Agreement

<table>
<tr><td colspan="2">By signing this attendance policy agreement form, I agree that I have reviewed the Attendance Policy given to me by Pathways Pediatric Therapies. I agree to the requirements and consequences of this policy.</td></tr>
<tr><td>Authorized Person Signature</td><td>Date of Signature</td></tr>
</table>