Center for Infant Tethered Oral Ties

Savoring the World with Occupational Therapy.

CONTRACT AGREEMENT

Dr. Christine M. Nguyen, OTD, OTR/L, CIMI, SWC
Licensed Occupational Therapist, #10522

Main Office
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Center for Infant Tethered Oral Ties

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S) FOR TREATMENT OF A MINOR AUTHORIZATION

MINOR FULL NAME _____ _____ _____
Last Name First Name Middle

ADDRESS _____ _____ _____ _____
Number and Street City State Zip Code

BIRTHDATE _____ **GENDER** ☐ Female
☐ Male

I, the undersigned, do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for Center for Infant Tethered Oral Ties to administer occupational therapy treatments to the Minor. I agree to assume financial responsibility for all expenses of such care in accordance with Center for Infant Tethered Oral Ties' Payment Terms.

This authorization is effective as of: _____

Parent/Legal Guardian Print Name: _____

Parent/Legal Guardian Signature: _____

Client Information

Center for Infant Tethered Oral Ties

Client Identification

Child's Last Name First Gender DOB

Home Address City State Zip

Primary Care Physician (Name, Phone Number)

Contact Information

Please provide names and the **BEST** possible phone number(s) and email. Be sure to notify us immediately of any changes.

Parent(s)/Legal Guardian(s) Name(s)

1. _____
Email: _____
Phone: _____
2._____
Email: _____
Phone: _____

Caregiver(s) Name(s) *People who might bring your child to therapy*

Name Relationship

Name Relationship

Emergency Contact Information:

Emergency Contact_____
Relationship_____

Phone Number_____

Center for Infant Tethered Oral Ties

Office Policies

At Center for Infant Tethered Oral Ties ("CITOT") we are committed to providing excellent care. In order to continue to provide this level of care we ask that all parents and guardians, on behalf of their minor children ("Client") respect the following policies.

1. **Safety and Supervision:** As we seek to provide a nurturing place for all patients, we ask that parents leave all other children at home, unless otherwise specified or recommended by Dr. Nguyen, OTD, OTR/L, CIMI, SWC. We are not responsible for the safety and supervision of non-patient children at the facility.
2. **Consultation charges:** We provide an initial 15-minute phone consultation free of charge. All other fees and costs are contained in an attached fee-schedule. All fees are subject to change by CITOT at any time.
3. **Cancellation policies:** All cancellations must be made at least 24 hours prior to the appointment time. Failure to provide 24-hour notice, day-of cancellation, or "no-shows" will result in the appointment being billed as a full charge at the discretion of CITOT.
4. **Insurance Information:** We do not bill insurance companies directly. Obtaining reimbursement from the patient's insurance provider is ultimately the Client's responsibility. CITOT will provide reasonable assistance to the patient by providing copies of any necessary documents to submit to the insurance provider such as invoices, bills or proof of treatment. If the insurance company requires a written report regarding the client's progress, you will be billed the rate of a progress report. Additional fees apply if CITOT is required to communicate with your insurance company.
5. **Financial responsibility:** Client is fully responsible for full payment of any and all services provided by CITOT to Client at the time of the appointment, regardless of insurance coverage. The patient is responsible for payment of any applicable co-payment quoted to CITOT by the Patient's insurance provider at the time of service.
6. **Photos & Videos:** As part of the therapy process CITOT may take photos and videos of patients in order to track and monitor progress. These images are solely for therapy purposes and will be retained by CITOT and not used for any other purpose unless otherwise authorized to so by you by your execution of the Media Release form, provided by CITOT.
7. **Joint Custody:** In the case of joint custody of a child, we request that both parents or guardians agree in writing to occupational therapy services before the child is scheduled for an evaluation and provide CITOT.
8. **COVID-19:** I acknowledge that I am fully and personally responsible for my own safety and actions during my presence in the Facilities. I recognize and acknowledge that I may, in any case, be at risk of contracting COVID-19 while engaged in the Therapeutic Activities or while using the Facilities, and that no amount of care, caution, instruction or expertise can eliminate such risk. With full knowledge of the risks involved, I hereby release, waive, and discharge the Released Parties from any and all liabilities, claims, demands, damages, expenses (including attorney's fees and costs), actions, and causes of action whatsoever, directly or indirectly, arising out of or related to any loss, damage, injury, or death that may be sustained related to COVID-19 and my participation, use of the Facilities, or while at the

premises owned or controlled by Company, whether or not caused by the negligent act or omission of the Released Parties. Safety precautions are displayed at the Facilities.

9. **Arbitration Agreement:** By signing this Agreement, the undersigned, for himself/herself and on behalf of their minor child agree that, if any dispute arises out of or relating to this agreement, the relationship, or the services performed (including but not limited to disputes regarding claims of negligence, breach of contract, fraud or any claim based on statute), such disputes shall be resolved by submission to binding arbitration in Los Angeles County, California, before a retired judge or justice. The prevailing party in any action or proceeding arising out of or to enforce any provision of this agreement will be awarded reasonable attorneys' fees and costs incurred in that action or proceeding, or in the enforcement of any judgment or award rendered in addition to any other relief that may be awarded.
Both CITOT and Client acknowledge that they are relinquishing their right to a jury trial in civil court. By signing this Agreement, the parties agree that arbitration is the exclusive remedy for all disputes related to CITOT's services.

By signing below, I agree on behalf of myself and the minor child to the foregoing policies of CITOT.

Date: _____

_____
Name of Child

_____ _____
Name of Parent/Guardian Signature of Parent /Guardian

_____ _____
Name of Parent/Guardian Signature of Parent /Guardian

Center for Infant Tethered Oral Ties

Privacy Statement for Patients

Confidentiality

Lastly, I understand that my child's records are protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA" herein), 42 USC §1320d and 45 CFR Parts 160, 164, and corresponding provisions of California law, e.g., the Lanterman-Petris-Short Act, and cannot be disclosed without prior written consent. Nonetheless, California state law requires CITOT and its representatives to report the suspicion of, or instance of, child abuse and/or neglect, which shall supersede the above-mentioned confidentiality requirements. In accordance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, we are publishing our privacy and security policies in regard to medical information. Your personal information is protected here at CITOT.

Under the law, your protected personal health information may be released to designated health plans or other healthcare providers without specific authorization in accordance with the law, to treat you/your child, obtain payment, and conduct normal practice operations. This is called a CONSENT FORM. We will ask you to sign our consent form for treatment here at CITOT. This consent is valid for all treatment and related operational activity. It may only be revoked by you in writing. If you wish a release of your protected health information for any other purpose, such as to obtain life or health insurance or for a therapist not associated with treatment here at this practice, you will need to sign a specific authorization. Please note that there may be a charge for copying medical records.

Privacy Policy

CITOT uses a variety of electronic communication methods including phone, text messages, e-mail to communicate with me for the limited purposes of appointments, available services, and other healthcare related communications, including complimentary text-messaging services to communicate with patients about appointments, provide photographs and video recordings, briefly respond to questions/concerns posed by You. By signing below, you authorize CITOT to disclose limited protected health information to other persons who may answer my electronic communications such as phone, text messages, or e-mail.

You have the right to restrict to whom all or any portion of your records may be released. These medical records will never be released to anyone unless specifically authorized by you in writing. The only exception to this rule, whereby records could be released without your authorization, would be in the course of legal investigations by state or federal agencies. If you feel, having read this policy, that you have a need to further restrict release of your records, please contact Dr. Christine Nguyen.

You have the right to inspect your medical records with reasonable notice to CITOT. You will then be allowed to inspect the records with CITOT. You have the right to ask that your medical records be amended. They cannot be erased or changed. Your therapist is not obligated to comply with the request to amend the record. Your request must be in writing to the treating therapist, and you will receive a written reply. A log of medical releases is kept in our office.

Center for Infant Tethered Oral Ties

You have the right to know where and when your personal healthcare information has been sent. You will be informed if and when there are any changes to this policy statement.

Patient Consent for Treatment and Release of Information

As required by the guidelines set forth under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have been given a copy of the privacy policy for CITOT and hereby consent to treatment for my child at CITOT. I Parent/Guardian on behalf of _____("Client") give CITOT my consent to use or disclose Client's protected health information to carry out my treatment, to share information with and between the multidisciplinary team (physicians, teachers, therapists, etc), and for health care operations such as quality reviews. I have been informed that I may review the CITOT's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent. I understand that CITOT has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic. I understand that CITOT is not required to agree to the request. If CITOT agrees to my request restriction, they must follow the restriction(s). I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed. I further understand that information for any other purpose may not be released to anyone without my specific authorization. I may, in writing, revoke this consent at any time, but it will not have any effect on actions taken prior to my revoking the consent.

Restrictions:

_____

_____

_____

Print Name: _____

Signature: _____

Date: _____

Center for Infant Tethered Oral Ties

Opt-In Programs

Consent to Send & Receive Text Messages

CITOT provides complementary text-messaging services to communicate with patients/team members about appointments, provide photographs and video recordings, briefly respond to questions, or concerns you may have about your child, etc. in accordance with its Privacy Policies, provided above.

By signing below, I authorize CITOT to contact me/team members by SMS text message for health-related notifications, which may include appointment reminders and other related messages and I agree to all terms and conditions of use for CITOT's text messaging services. I understand that message/data rates may still apply to messages sent by CITOT under my cell phone plan. I know that I am under no obligation to authorize CITOT to send me text messages and that I may opt-out of receiving these communications at any time by texting STOP to (626) 940-4245 or (310) 869-8294. I understand that text messages are not a substitute for professional or medical attention.

Print Name: _____

Signature: _____

Date: _____

Center for Infant Tethered Oral Ties

Credit Authorization Form

I, _____, authorize Center for Infant Tethered Oral Ties, ("CITOT"), to charge the credit card indicated in this authorization form on a one-time basis for a consultation fee and/or on a periodic basis in accordance with the terms and conditions of this agreement. If a payment due date falls on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that this authorization will remain in effect until any amounts due and payable hereunder have been fully discharged or I cancel it in writing, whichever comes first, and I agree to notify CITOT in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company, so long as the transaction corresponds to the terms indicated in this form.

Name on Card: _____

Type of Credit Card: ☐**Visa** ☐**MasterCard** ☐**American Express**

Credit Card Number: _____

Expiration Date: _____ **SVC Code**: _____

Billing Address: _____

City: _____ **State**: _____ **Zip Code**: _____

E-mail Address: _____

Phone Number: _____

Print Name: _____

Signature: _____

Payments

Payments can be also made with checks (made out to One Child), cash, VENMO, ZELLE, PAYPAL.

*Fees are subject to change with written notice from CITOT.