Elite DNA Therapy Services
a comprehensive approach

Pediatric Intake Form

Demographics

Patient Name: _____ [ ] Male [ ] Female
Date of Birth: _____ Patient Social Security Number: _____
Ethnicity: _____ Preferred Language: _____
Current Diagnosis (if any): _____
Name (Person completing this form): _____ Relationship to Patient: _____
Home Address: _____ Primary Phone: _____
_____ Secondary Phone: _____

Doctor Information

Child's Primary Physician: _____ Child's Referring Physician: _____
Phone: _____ Phone: _____Specialty: _____

Guardian Information (Elite DNA Therapy Services, LLC may request Legal Guardianship Documents)

Guardian Name: _____ Occupation: _____
Relationship to Patient: _____ Home Phone: _____
Date of Birth: _____ Cell Phone: _____
Social Security Number: _____ Work Phone: _____
Marital Status: _____ E-mail Address: _____

Guardian Name: _____ Occupation: _____
Relationship to Patient: _____ Home Phone: _____
Date of Birth: _____ Cell Phone: _____
Social Security Number: _____ Work Phone: _____
Marital Status: _____ E-mail Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Insurance Type: _____ Secondary Insurance Type: _____
Member ID Number: _____ Member ID Number: _____
Group Number: _____ Group Number: _____
Policy Holder's Name: _____ Policy Holder's Name: _____
Policy Holder's DOB: _____ Policy Holder's DOB: _____
Policy Holder's Social Security Number: _____ Policy Holder's Social Security Number: _____

Presenting Concerns

Please describe your primary concerns. (How long have you noticed this?) _____

_____

Have you already tried to address these concerns? [ ] Yes [ ] No [ ] Unsure

Were the efforts effective? [ ] Yes [ ] No [ ] Unsure

Was there an event that caused you to seek treatment now? [ ] Yes [ ] No [ ] Unsure

Current Symptoms Checklist

Personal/Social Adjustment

[ ] Unduly sad
[ ] Overly anxious, shy, or withdrawn
[ ] Verbally aggressive
[ ] Temper tantrums
[ ] Physically aggressive
[ ] Harms self or others (suicidal or homicidal)
[ ] Disturbing habits or mannerisms
[ ] Problems with the law
[ ] Strange or bizarre behavior
[ ] Paranoia or hallucinations
[ ] Problems in peer relationships
[ ] Drug or alcohol problems
[ ] Other: _____

Family Adjustment

[ ] Parent-child problem
[ ] Separation from parent
[ ] Marital conflict
[ ] co-parenting problems
[ ] Sibling conflict
[ ] Domestic violence
[ ] History of loss or abandonment
[ ] Neighborhood difficulties
[ ] Mother experiencing difficulties
[ ] Father experiencing difficulties
[ ] Sibling experiencing difficulties
[ ] Drug or alcohol problems in family
[ ] Other: _____

School Adjustment

[ ] Academic problems
[ ] Difficulty with peers
[ ] Difficulty with authority
[ ] Poor attendance/reluctance to go to school
[ ] Behavior problems
[ ] Learning disabilities
[ ] Attention problems
[ ] Aches and pains related to school
[ ] Other: _____

Physical/Developmental Factors

[ ] Eating
[ ] Sleeping
[ ] Toileting
[ ] Grooming
[ ] Language or speech
[ ] Perceptual/visual functions
[ ] Motor coordination problems
[ ] Other: _____

Prenatal History

Mother's health during pregnancy: [ ] Unsure [ ] Normal [ ] Poor

Age of mother at child's birth: _____ [ ] Unsure

Did the mother have any exposure to drugs, alcohol, or tobacco during the pregnancy? [ ] Yes [ ] No [ ] Unsure

The child's birth was:

[ ] On schedule
[ ] Born early _____ weeks premature
[ ] Born late _____ weeks overdue
[ ] Unsure

Prenatal History (continued)

The delivery was:

[ ] Normal
[ ] Breech
[ ] Caesarian
[ ] Forceps
[ ] Suction
[ ] Induced
[ ] Unsure

Duration of labor: _____ [ ] Unsure
Length: _____ [ ] Unsure
Child's birth weight: _____ [ ] Unsure
APGAR Score: _____ [ ] Unsure

Were there complications following birth: [ ] Yes [ ] No [ ] Unsure

Postnatal Period, Infancy, Toddler

Feeding problems: [ ] Yes [ ] No [ ] Unsure
Sleep problems: [ ] Yes [ ] No [ ] Unsure
Responsiveness/alertness problems: [ ] Yes [ ] No [ ] Unsure
Were there health or congenital problems during infancy: [ ] Yes [ ] No [ ] Unsure

How was it to care for patient:
[ ] Very easy
[ ] Easy
[ ] Average
[ ] Difficult
[ ] Very Difficult
[ ] Unsure

How sociable was patient:
[ ] More Sociable than Average
[ ] Average Sociability
[ ] More Unsociable than Average
[ ] Unsure

Rate the activity level of patient:
[ ] Very Active
[ ] Active
[ ] Average
[ ] Less Active
[ ] Not Active
[ ] Unsure

Developmental Milestones

Age child sat up:
[ ] 3-6 months
[ ] 7-12 months
[ ] Over 12 months
[ ] Unsure

Age child crawled:
[ ] 6-12 months
[ ] 13-18 months
[ ] Over 18 months
[ ] Unsure

Age child walked alone:
[ ] Under 1 year
[ ] 1-2 years
[ ] 2-3 years
[ ] Unsure

Age child started speaking single words:
[ ] 9-13 months
[ ] 14-18 months
[ ] 19-24 months
[ ] 25-36 months
[ ] 37-48 months
[ ] Unsure

Age child strung two or words together:
[ ] 9-13 months
[ ] 14-18 months
[ ] 19-24 months
[ ] 25-36 months
[ ] 37-48 months
[ ] Unsure

Age toilet trained: _____

Bladder controlled:
[ ] Under 1 year
[ ] 1-2 years
[ ] 2-3 years
[ ] 3-4 years
[ ] Unsure

Bowel controlled:
[ ] Under 1 year
[ ] 1-2 years
[ ] 2-3 years
[ ] 3-4 years
[ ] Unsure

How long did toilet training take?
[ ] Less than 1 month
[ ] 1-2 month
[ ] 2-3 months
[ ] More than 3 months
[ ] Unsure

Medical History

Date of last complete physical exam: _____

Any significant or relevant medical problems and age diagnosed:

[ ] Surgeries, age: _____
[ ] Illnesses, age: _____
[ ] Injuries, age: _____
[ ] Head Trauma, age: _____
[ ] Seizures, age: _____
[ ] Other: _____, age: _____

Have other specialties or other professionals have treated/are treating patient: [ ] Yes [ ] No [ ] Unsure
Is patient currently taking and medication? [ ] Yes [ ] No [ ] Unsure
Allergies: [ ] Yes [ ] No [ ] Unsure
Vision problems: [ ] Yes [ ] No [ ] Unsure
Hearing problems: [ ] Yes [ ] No [ ] Unsure
Any other health problems: [ ] Yes [ ] No [ ] Unsure
Any disabilities that could impact patient's [ ] Yes [ ] No [ ] Unsure

Psychiatric History

Has patient ever received any of the following services or feelings?

- Individual Therapy: [ ] Yes [ ] No [ ] Unsure
- Family Therapy: [ ] Yes [ ] No [ ] Unsure
- Group Therapy: [ ] Yes [ ] No [ ] Unsure
- Applied Behavior Analysis (ABA): [ ] Yes [ ] No [ ] Unsure
- Speech Therapy: [ ] Yes [ ] No [ ] Unsure
- Occupational Therapy: [ ] Yes [ ] No [ ] Unsure
- Psychological Testing: [ ] Yes [ ] No [ ] Unsure
- Inpatient (Hospital or Residential): [ ] Yes [ ] No [ ] Unsure
- Past Suicidal Ideation: [ ] Yes [ ] No [ ] Unsure
- Current Suicidal Ideation: [ ] Yes [ ] No [ ] Unsure
- Aggressive Behavior or Homicidal Ideation/Behavior: [ ] Yes [ ] No [ ] Unsure
- Previous Diagnosis: [ ] Yes [ ] No [ ] Unsure

Please mark all **past** psychiatric medications.

Antidepressants

[ ] Prozac (fluoxetine)
[ ] Zoloft (sertraline)
[ ] Luvox (fluvoxamine)
[ ] Celexa (citalopram)
[ ] Lexapro (escitalopram)
[ ] Paxil (paroxetine)
[ ] Pristiq (desvenlafaxine)
[ ] Cymbalta (duloxetine)
[ ] Effexor (venlafaxine)
[ ] Wellbutrin (Bupropion)
[ ] Remeron (mirtazapine)
[ ] Viibryd (vilazodone)
[ ] Trintellix (vortioxetine)
[ ] Elavil (amitriptyline)
[ ] Anafranil (clomipramine)
[ ] Sinequan (doxepin)
[ ] Tofranil (imipramine)
[ ] Pamelor (nortriptyline)
[ ] Savella (milnacipran)
[ ] Fetzima (levomilnacipran)
[ ] Other: _____

Anti-Anxiety (Anxiolytics)

[ ] Xanax (alprazolam)
[ ] Buspar (buspirone)
[ ] Ativan (lorazepam)
[ ] Vistaril (hydroxyzine)
[ ] Klonopin (clonaxepam)
[ ] Valium (diazepam)
[ ] Librium (chlordiazepoxide)
[ ] Tranxene (clorazepate)
[ ] Serax (oxazepam)
[ ] Other: _____

Typical Antipsychotics

[ ] Thorazine (chlorpromazine) [ ] Haldol (haloperidol) [ ] Other: _____

Atypical Antipsychotics/Mood Stabilizers

[ ] Abilify (aripiprazole) [ ] Risperdal (risperidone) [ ] Rexulti (brexpiprazole)
[ ] Clozaril (clozapine) [ ] Geodon (ziprasidone) [ ] Invega (paliperidone)
[ ] Latuda (lurasidone) [ ] Haldol (haloperidol) [ ] Fanapt (iloperidone)
[ ] Zyprexa (olanzapine) [ ] Prolixin (fluphenazine) [ ] Other: _____
[ ] Seroquel (quetiapine) [ ] Saphris (asenapine)

Mood Stabilizers

[ ] Lithium [ ] Lamictal (lamotrigine) [ ] Depakote (valproate)
[ ] Tegretol (carbamazepine) [ ] Trileptal (oxcarbazepine) [ ] Other: _____
[ ] Neurontin (gabapentin) [ ] Topamax (topiramate)

Sedatives/Sleep Aides

[ ] Ambien (zolpidem) [ ] Restoril (temazepam) [ ] Belsomra (suvorexant)
[ ] Sonata (zaleplon) [ ] Desyrel (trazodone) [ ] Other: _____
[ ] Rozerem (ramelteon) [ ] Lunesta (eszopiclone)

ADHD Medications

[ ] Adderall (amphetamine) [ ] Daytrana (methylphenidate) [ ] Mydayis (mixed amphetamine salt)
[ ] Adderall XR [ ] Metadate (methylphenidate)
[ ] Evekeo (amphetamine) [ ] Dyanavel XR [ ] Cotempla XR (methylphenidate)
[ ] Zenzedi (amphetamine) [ ] Strattera (atomoxetine)
[ ] Adzenys XR (amphetamine) [ ] Quillivant XR [ ] Other: _____
[ ] Concerta (methylphenidate) [ ] Kapvay (clonidine)
[ ] Ritalin (methylphenidate) [ ] Tenex/Intuniv (gunanfacine)

Family History (Please indicate if any family members have been diagnosed or experience any of the following)

	Mother	Father	Sibling	Maternal Grandparents	Paternal Grandparents	Other
Depression						
Anxiety						
Substance abuse						
Learning disability						
ADHD						
Bipolar disorder						
Psychosis/Schizophrenia						
OCD						
Suicidal behavior						
Self-harm/cutting						
Seizure disorder						
Autism spectrum						
Intellectual disability						
Abuse						
Thyroid problem						
Other						

Social History

Parents marital status:

[ ] Married for: _____
[ ] Unmarried but together for: _____
[ ] Separated since patient was: _____
[ ] Legally divorced since patient was: _____
[ ] Never together

Please describe custody arrangement, including medical decision making (Elite DNA Therapy Services, LLC may request Legal Guardianship Documents): _____

_____

_____

Who is living in the home? (please descried names, ages and relationship to the patient): _____

_____

_____

School History

School Attended: _____ School Phone: _____

Did patient have to repeat a grade? [ ] Yes [ ] No [ ] Unsure
Has patient ever been suspended? [ ] Yes [ ] No [ ] Unsure
Does patient require special services in school (either an IEP or a 504B plan)? [ ] Yes [ ] No [ ] Unsure
Is patient in the gifted program? [ ] Yes [ ] No [ ] Unsure
Patient's weakest subject is: _____
Does patient have involvement in any extra-curricular activities? [ ] Yes [ ] No [ ] Unsure
Does patient's teacher(s) have any concerns? [ ] Yes [ ] No [ ] Unsure
Has patient ever had other evaluations? (i.e. Academic, Speech, Occupational Therapy) [ ] Yes [ ] No [ ] Unsure

Substance Use

Does patient use alcohol? [ ] Yes [ ] No [ ] Unsure
Does patient use recreational drugs? [ ] Yes [ ] No [ ] Unsure
Is patient exposed to alcohol or recreational drugs? [ ] Yes [ ] No [ ] Unsure

Habits/Activities of Daily Living

Are there any concerns around bedtime? [ ] Yes [ ] No [ ] Unsure
Patient generally sleeps from: _____ to _____
Does patient sleep independently? [ ] Yes [ ] No [ ] Unsure
Are there any concerns about patient's eating habits/appetite/nutrition? [ ] Yes [ ] No [ ] Unsure
Has patient reached menses? [ ] Yes [ ] No [ ] Unsure [ ] N/A
Is patient dating? [ ] Yes [ ] No [ ] Unsure
Is patient sexually active? [ ] Yes [ ] No [ ] Unsure
Any habits or repetitive behaviors that concern you? [ ] Yes [ ] No [ ] Unsure
Briefly List: _____
How would you characterize patient's mood, most of the time? [ ] Good [ ] Fair [ ] Poor
Patient's interests and strengths: _____

Trauma History

Has patient ever experienced or witnessed any kind of abuse? [ ] Yes [ ] No [ ] Unsure

- Emotional abuse: [ ] Yes [ ] No [ ] Unsure
- Physical abuse: [ ] Yes [ ] No [ ] Unsure
- Sexual abuse: [ ] Yes [ ] No [ ] Unsure
- Neglect: [ ] Yes [ ] No [ ] Unsure

Other agencies involved currently or previously involved with the patient or patient's family (Elite DNA Therapy Services, LLC may request Legal Guardianship Documents):

- DCF: [ ] Yes [ ] No [ ] Unsure
- Probation officer: [ ] Yes [ ] No [ ] Unsure
- Other: [ ] Yes [ ] No [ ] Unsure

Psychosocial stressors (Please indicate as many as you believe may impact patient):

[ ] New House
[ ] Birth of sibling
[ ] Death or illness in the family
[ ] Change in caregiver
[ ] Family legal/financial problems
[ ] Prolonged separation from parent
[ ] Other: _____

Spiritual Life

Does patient or patient's family belong to a religious group? [ ] Yes [ ] No [ ] Unsure [ ] Prefer not to answer
Are there any cultural factors that could impact patient's treatment? [ ] Yes [ ] No [ ] Unsure

Any other information you wish the provider to know: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Printed Name of Parent or Guardian Relationship to Patient

_____ _____
Signature of Parent or Guardian Date

Elite DNA Therapy Services, LLC
General Consent for Treatment

Patient Name: _____ Date of Birth: _____

Consent for Treatment

I hereby voluntarily give my consent for myself, my child, or my family to receive one or more of the following services or treatments provided by Elite DNA Therapy Services, LLC: Psychiatry, Psychotherapy, Medication Management, Occupational Therapy (OT), Speech Therapy (ST), Advanced Behavioral Analysis (ABA), Transcranial Magnetic Stimulation (TMS), Mental Health, or Substance Abuse and Addiction Medicine services, all within the professional medical judgement and discretion of Elite DNA Therapy Services, LLC's doctors, nurse practitioners, and staff. I further consent to the collection and use of past and current medical and medicine history of patient, patient's family, patient's providers, including pharmacies from which prescriptions have been obtained. I consent to the use of photography for purposes of verifying identification of patients and/or identifying accompanying persons. Because I have the right to refuse services at any time, I understand and agree that my or my family's continued participation in services or treatments offered by Elite DNA Therapy Services, LLC implies informed consent. If I choose to revoke this consent, I understand that providers and/or clinic staff may not be able to provide to me, my child, or family members necessary services and treatments that have been recommended. I further understand that Elite DNA Therapy Services, LLC participates in educational programs and that students in these affiliated programs may be involved in care provided.

_____ (initials) I understand that potential benefits of undergoing services offered by Elite DNA Therapy Services, LLC may include improvement in functioning of myself or child and/or an increased understanding of myself and/or child. I understand that potential risks may include possible disagreement with opinions offered to me, and possible emotional distress concerning my situation. I understand that alternative procedures may include services provided by other psychologists, psychiatrists, or mental health professionals.

_____ (initials) I understand that while the evaluation and/or treatment will be based upon known principles and research, the practice is not an exact science. I acknowledge that no guarantees have been made to me concerning the results of evaluations and/or treatments or services provided by Elite DNA Therapy Services, LLC.

_____ (initials) I verify that I am the patient **OR** patient's legal guardian per Florida State Statute Chapter 744 for the above and furthermore certify that the information, records, and other documents I have provided to Elite DNA Therapy Services, LLC (either verbally or in writing) are accurate to the best of my knowledge.

_____ (initials) I hereby acknowledge that I have reviewed the Notice of Privacy Practice(NPP) and the Patients' Rights and Responsibilities documents. I can request copies. Elite DNA Therapy Services, LLC must post NPPs. Signed copies of consents, agreements, and authorizations can be used in place of original scanned into medical record chart.

By signing below, I am agreeing to consent for treatment and my understanding of the information described in this document. I have read this consent and have been able to ask questions.

_____ _____

Printed Name of Patient or Guardian Relationship to Patient

_____ _____

Signature of Patient or Guardian Date

Elite DNA Therapy Services, LLC

Permission to Discuss Protected Health Information (PHI)
Others Who are Involved in Your Healthcare

(Not to Be Used as Authorization to Release Information)

Patient Name: _____ Date of Birth: _____

I hereby permit Elite DNA Therapy Services, LLC to share specific information described below, only for the purposes and persons involved in my healthcare.

Description of the specific information to be discussed:

[ ] Appointment Date/Times [ ] Summary of Medical Record [ ] Pick Up Prescriptions
[ ] Diagnosis [ ] Care Plan [ ] Other (specify): _____
[ ] Medications Lab Tests/Results [ ] Genetic Testing Results

Indicate Confidential Information you **don't want discussed**:

[ ] Mental Health [ ] Medication [ ] HIV information [ ] Alcohol/Drug Information

Information provided to:

Full Name: _____ Full Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Relationship to Patient: _____ Relationship to Patient: _____

It is my responsibility to inform Elite DNA Therapy Services, LLC of changes and to revoke and complete another form.

I understand that:

- This document does not dictate that our providers will initiate conversations or other methods to share information with persons listed above. If those persons wished to be involved, then it is their duty to initiate involvement, and if time and circumstances permit, then Elite DNA Therapy Services, LLC will do our best to comply to your wishes.
- I may revoke this permission in writing by contacting our office manager or Privacy Officer.
- Information shared may be subject to re-disclosure by the recipient and no longer be protected under HIPAA.
- **This document is intended to relieve burden of our staff to know to whom you want to involve in this patient's care. It is not mandatory to complete.**
- **This document is not an authorization to release protected health information (PHI).**
- **Information Excluded from the Right of Access: Psychotherapy notes, which are the personal notes of a mental health care provider documenting or analyzing the contents of a counseling session, that are maintained separate from the rest of the patient's medical record. (45 CFR 164.524(a)(1)(i) and 164.501)**

_____ _____

Printed Name of Patient or Guardian Relationship to Patient

_____ _____

Signature of Patient or Guardian Date

Elite DNA Therapy Services, LLC

General Policies, Insurance Assignments, and Financial Agreement

Patient Name: _____ Date of Birth: _____

General Policies

_____ (initials) **Emergency Services –** Elite DNA Therapy Services, LLC is not a 24-clinic and WE DO NOT PROVIDE EMERGENCY SERVICES. For emergencies call 911 or go to nearest emergency room. For non-life-threatening after-hours services, please call the office and follow prompts.

_____ (initials) **Missed/Cancelled Appointments –** A patient who fails to appear or cancels less than 24 hours in advance of an appointment may be subject to a $40 fee and may be discharged. Please remember to reschedule ahead of time and we will attempt to accommodate your requests. Since "things happen," patients will be permitted to miss one appointment in a 6-month period without being penalized. However, please know that repeated "no-shows" may jeopardize your ability to receive treatment.

_____ (initials) **Lateness –** Due to stringent billing requirements, we will be unable to see patients who are late for their appointment. Please call to let us know if you are running late and we will attempt to reschedule your appointment, as needed. However, you may be subject to a $40 fee or suspension of services if you are not able to maintain your appointments.

_____ (initials) **Absence for More than 6 Months –** If you cancel or miss your appointments for longer than a 6-month period, you may be considered a new patient and another intake appointment may be necessary. Also, you may be placed on a waiting list.

_____ (initials) **Communications –** You understand that you may receive calls from Elite DNA Therapy Services, LLC or third-party business associates for purposes of including, but not limited to, results communication, patient surveys, and debt collection using the phone numbers, including wireless numbers you have provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

_____ (initials) **Confidentiality and Release of Protected Health Information (PHI) –** All information disclosed within sessions is confidential and may not be revealed to anyone outside of the Elite DNA Therapy Services, LLC without written permission, except for disclosures as required by law. The law does require clinicians to report to the authorities any reasonable suspicions of child or elder abuse, or danger of harm to self and/or to others unless protective measures are taken. To the extent necessary to determine insurance benefits or liability for payment and to obtain reimbursement, Elite DNA Therapy Services, LLC may disclose portions of the patient's medical record and account file to any person or corporation that may be liable for all or any portion of the patient's charges, including but not limited to insurance companies, health care service plans or workers' compensation carriers. Elite DNA Therapy Services, LLC may disclose information to referring provider following the minimum necessary rule.

Insurance Assignments

_____ (initials) **Fees for Clinical Services –** At Elite DNA Therapy Services LLC, we accept many insurance plans, single case agreements, and private pay. Please inquire about our fees, as the rates may be different depending on which provider you are seeing. Please know that you may be billed for telephone calls, written reports or other services that specifically require the provider's time outside of scheduled appointments.

_____ (initials) **Assignment of Insurance Benefits –** In consideration of services rendered, I hereby transfer and assign to Elite DNA Therapy Services, LLC all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance.

_____ (initials) **Medicare / Medicaid –** I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me may send to responsible carriers, or their intermediaries, any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treatment me.

Financial Agreement

_____ (initials) **Payment Responsibility –** I understand that insurance claims are filed as a courtesy. If a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the provider for services rendered to the patient. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. I authorize direct payment to be made to Elite DNA Therapy Services, LLC for all services and treatments rendered. I understand if any services or treatments charges are not covered by my insurance carrier or my eligibility cannot be verified, I am responsible for all charges incurred. Furthermore, it is an agent or patient's responsibility to know insurance coverage for services, as some services and general medical coverage may be provided by two separate plans. I understand that it is my responsibility to pay any co-pay, deductible, co-insurance, or any other balance not paid for by insurance or third-party payor within a reasonable time not to exceed 30 days. If you are considered the guarantor, you will provide your name, Date of Birth, and Social Security Number to satisfy requirements to bill insurance companies. Our office staff is happy to help answer questions and help with this process.

_____ (initials) **Financial Agreement –** The signatory agrees, whether signatory signs as agent or as patient, that in consideration of services to be rendered to patient, signatory obligates them to pay charges for services received in accordance with regular rates and terms of Elite DNA Therapy Services, LLC. We reserve the right to assign unpaid bills to a collection agency. Should your account be referred to an attorney for collections, the signatory should pay reasonable attorney's fees and collection expense. If you have any questions about by this agreement, please feel free to ask for clarification.

The signatory certifies that he or she has read, understands, and accepts these terms and conditions of this document and is either the patient or is duly authorized by the patient as patient's general agent to execute the above agreement and may receive a copy upon request.

Printed Name of Patient or Guardian	Relationship to Patient
Signature of Patient or Guardian	Date

You have the right to request copies of all signed documents.

Elite DNA Therapy Services, LLC

Authorization and Consent for Other Individuals to Accompany Minor

Patient Name: _____ Date of Birth: _____

_____ (initials) I understand and agree that I am not required to authorize any other individual to present or accompany minor named above to Elite DNA Therapy Services, LLC. However, by completing this authorization, I am voluntarily giving consent for the individual(s) named below to bring minor named above to Elite DNA Therapy Services, LLC for to receive services described in the General Consent for Treatment.

_____ (initials) I likewise, understand and agree that my authorization and consent does not replace my responsibility for cooperation and involvement in the treatment of minor named above as outlined and agreed to by signing the General Consent for Treatment.

_____ (initials) I fully understand for psychiatric appointments no medication changes will be completed without custodial written approval. I have been informed that professional judgement Elite DNA Therapy Services, LLC will be exercised regarding any changes in treatment when minor named above is accompanied by an authorized alternative individual below to whom I give my authorization and consent to accompany minor named above.

_____ (initials) Furthermore, I hereby certify that the alternative individual(s) named below may lawfully be described as one of the statutorily allowable individuals who may provide consent for medical care of a minor under Fla. Stat. § 743.0645, such that each person is either a “health care surrogate”, “stepparent”, “grandparent”, “adult sibling”, or “adult aunt or uncle” of minor. Individuals with any relationship to minor other than those described in the preceding sentence have my explicit consent to accompany minor named above.

_____ (initials) I understand that I may revoke this authorization and consent of individual(s) listed below at any time.

I hereby authorize and consent that the following individual(s) may accompany my minor named above to appointments at Elite DNA Therapy Services, LLC (Use back of page if more persons are added.):

Full Name: _____

Address: _____

_____

DOB: _____

Relationship to Patient: _____

Full Name: _____

Address: _____

_____

DOB: _____

Relationship to Patient: _____

_____ _____

Printed Name of First Patient or Guardian Relationship to Patient

_____ _____

Signature of First Patient or Guardian Date

_____ _____

Printed Name of Second Patient or Guardian Relationship to Patient

_____ _____

Signature of Second Patient or Guardian Date

Elite DNA Therapy Services, LLC
Custody Status Agreement

Patient Name: _____ Date of Birth: _____

[ ] Check Here if there has NEVER BEEN A DISPUTE REGARDING CUSTODY OF MINOR. Sign and date below.

_____ (initials) I understand and agree if any information provided to Elite DNA Therapy Services, LLC has been misrepresented or if important changes of information are not timely communicated to Elite DNA Therapy Services, LLC, such misrepresentations or failures to disclose may result in suspension or termination of services.

_____ (initials) By completing this Agreement, I certify that there is a final decision or an ongoing custody dispute and/or custody consideration and a court order regarding custody has not been issued. Regardless of status, as a legal guardian of minor named above, I understand that it is my responsibility to inform all legal guardians that minor is receiving services at Elite DNA Therapy Services, LLC.

_____ (initials) I understand and agree to provide copies of official legal documentation to Elite DNA Therapy Services, LLC as soon as possible and / or if there are changes or decisions made regarding custody considerations.

_____ (initials) I understand and agree that if lack of cooperation or participation of minor's legal guardians or if custody issues or disputes are hindering or otherwise preventing appropriate treatment of minor; treatment and services may be suspended or terminated by our sole discretion. Elite DNA Therapy Services, LLC will not become involved in disputes between guardians (legally appointed or not) and has the right to suspend or terminate treatments or services if disputes become disruptive or adversarial in the best interests of our staff, patients, and visitors.

_____ (initials) I understand and agree that it shall be within the medical and professional judgement and discretion of Elite DNA Therapy Services, LLC to provide appropriate services. I understand and agree it is my responsibility to put the emotional and mental health needs of the minor before any custody or legal complications. I agree I will fully cooperate and participate in the minor's treatment, and likewise will encourage all legal guardians to cooperate and participate to the extent it is appropriate and legally permissible to do so.

_____ (initials) I understand that all legal guardians have rights to obtain patient medical records upon request. However, if there are any conflicts, disputes, legal ramifications, or authorization concerns, Elite DNA Therapy Services, LLC, using their medical and professional judgement may withhold release of such records on behalf of minor. In such a situation, Elite DNA Therapy Services, LLC is asserting the psychotherapist-patient privilege on behalf of minor pursuant to Florida Statutes § 90.503(3).

_____ _____
Printed Name of First Patient or Guardian | Relationship to Patient

_____ _____
Signature of First Patient or Guardian (only one signature is required) | Date

_____ _____
Printed Name of Second Patient or Guardian | Relationship to Patient

_____ _____
Signature of Second Patient or Guardian | Date

Patient's Bill of Rights and Responsibilities

Section 381.026, Florida Statutes

A patient has the right to:

- Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy. Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and is responsible for his or her care.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given full information and necessary counseling on the availability of known financial resources for care.
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.
- Express complaints regarding any violation of his or her rights.

A patient is responsible for:

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His or her actions if treatment is refused or if the patient does not follow the health care provider's instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.

Agency for Health Care Administration – Visit us at www.FloridaHealthFinder.gov

If you have questions or concerns, please contact our Privacy Officer.
Phone: 239.223.2751
Emal: Privacy@EliteDNATherapy.com
Hotline: 888.453.3114

Elite DNA Therapy Services, LLC
Notice of Privacy Practices

Purpose:
This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Our Commitment to Your Privacy
Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI) or Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. At Elite DNA Therapy Services, the privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. Our practice will also post a copy in our office in a visible location always.

Understanding Your Health Record/Information
Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when, where, and why others may access your health information
- Make more informed decisions when authorizing disclosure to others

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- Request to amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Right to A Copy of Your Medical Records
This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. To inspect and copy medical information that may be used to make decisions about you, you must contact the office to obtain an Authorization Form. Once you have received this form, please fill it out thoroughly and send the form back to the office.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed.

Right to Request Restrictions
You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Please discuss any restriction you wish to request with your physician. You may request a restriction by contacting the office for a "Request of Restrictions Form". This form must be submitted to our office.

Right to Amend
This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to obtain the "Health Record Amendment Form". This form must be submitted to our office.

Right to Receive Certain Accounting Disclosures
This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. Please contact our Privacy Officer to obtain the "Request for Accounting Disclosures Form". This form must be submitted to our office.

Right to Obtain A Paper Copy
You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, please contact the Office.

Our Responsibilities
Elite DNA Therapy Services, LLC is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

How We May Use and Disclose Your Information Treatment
For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

Payment
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Healthcare Operations
For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates
There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Appointment Reminders
We may contact you by phone or leave a message on your home, work or cell phone as a reminder that you have an appointment scheduled for medical care at the office. Please notify us if you do not wish to be contacted for appointment reminders.

Notification
We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family Members
Health professionals, using their best judgment, may disclose to a family member, other relative, close friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Disclosures Required by Law
We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state, or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Military and National Security
When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation/Health Oversight Activities
Your Protected Health Information may be disclosed by us as authorized to comply with Workers' Compensation laws and other similar legally-established programs.

We may disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your medical information in response to a court or administrative order. We may also disclose your medical information in response to a subpoena.

Coroners, Medical Examiners and Funeral Directors
We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death.

Other Uses and Disclosures of Health Information
We will not use or disclose your Protected Health Information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization in writing at any time. If you revoke the Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. We cannot release you're your Psychotherapy Notes without a special signed, written authorization (different than the Authorization mentioned above) from you. To disclose these types of records for purposes of treatment, payment or health care operations, we will have to have a special written authorization that complies with the law.

Food and Drug Administration (FDA)
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Correctional Institution
Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Complaints (Anonymous Hotline Number 888.453.3114)
There will be no retaliation for filing a complaint.

If have questions and would like additional information, you may contact our Privacy Officer at 239.223.2751

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer at 239.223.2751 or privacy@elitednatherapy.com.

OR with the Secretary of Health and Human Services by using the information below:
Timothy Noonan, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD :(800) 537-7697
Email: ocrmail@hhs.gov

This revised notice was published and becomes effective on January 30, 2018.