Elite DNA Therapy Services
a comprehensive approach

Child Intake Form

Patient Name: _____ Date of Birth: _____ Age: _____ M F
Ethnicity: _____ Preferred Language: _____
Current Diagnosis (if any): _____
Name (Person completing this form): _____ Relationship to Patient: _____
Home Address: _____ Primary Phone: _____
_____ Secondary Phone: _____
School Attended: _____ Teacher: _____
School Phone: _____ Grade: _____
Child's Primary Physician: _____ Address: _____
Phone: _____ _____
Child's Referring Physician: _____ Address: _____
Phone: _____Specialty: _____ _____

Guardian Information Section

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

Second 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 Section

Primary Insurance Type: _____ Secondary Insurance Type: _____
Patient Social Security Number: _____ Patient Social Security Number: _____
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? _____
What have you already done to address these concerns and how effective were these efforts? _____
_____
_____
Was there an event that caused you to seek treatment now? _____
_____
_____

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[ ] Overly anxious, shy, or withdrawn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: _____

Developmental Factors

Physical/Developmental Factors

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

Prenatal History

How was mother's health during pregnancy? _____
_____
_____

Age of mother at child's birth? _____

Did the mother have any exposure to drugs, alcohol, caffeine, or tobacco during the pregnancy?
[ ] No [ ] Yes (please describe): _____

The child's birth was:
[ ] On schedule [ ] Born early _____ weeks premature [ ] Born late _____ weeks overdue

Duration of labor? _____

The delivery was:
[ ] Normal [ ] Caesarian [ ] Suction
[ ] Breech [ ] Forceps [ ] Induced

Child's birth weight? _____ Length? _____ APGAR Score _____

Were there complications following birth? [ ] No [ ] Yes (please describe): _____
_____
_____

Postnatal Period / Infancy / Toddler

Feeding problems? [ ] No [ ] Yes (please describe): _____
_____
_____

Sleep problems? [ ] No [ ] Yes (please describe): _____
_____
_____

Responsiveness/alertness problems? [ ] No [ ] Yes (please describe): _____
_____
_____

Were there health or congenital problems during infancy? [ ] No [ ] Yes (please describe): _____
_____

How was it to care for this child?
[ ] Very easy [ ] Easy [ ] Average [ ] Difficult [ ] Very Difficult

How did the child behave with other people?
[ ] More Sociable than Average [ ] Average Sociability [ ] More Unsociable than Average

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

Developmental Milestones

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

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

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

Age child spoke single words other than 'mama' or 'dada'?
[ ] 9-13 months [ ] 14-18 months [ ] 19-24 months [ ] 25-36 months [ ] 37-48 months

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

Age toilet trained?

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

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

How long did toilet training take from onset to completion?
[ ] Less than 1 month [ ] 1-2 month [ ] 2-3 months [ ] More than 3 months

Medical History

Any significant or relevant medical problems and age diagnosed (including any surgeries, illnesses, injuries, head trauma or seizures)? [ ] No [ ] Yes (please describe): _____
_____
_____

Date of last complete physical exam: _____

Please list the names and specialties of other professionals who have treated/are treating your child:
_____
_____
_____

List all ***current*** prescription medications, over-the-counter medications, or supplements and how often your child takes them: [ ] No current medications _____
_____
_____

Allergies: [ ] None [ ] Yes (please describe): _____
_____
_____

Vision Problems: [ ] None [ ] Yes (please describe): _____
_____
_____

Hearing Problems: [ ] None [ ] Yes (please describe): _____
_____
_____

Other: [ ] None [ ] Yes (please describe): _____

Psychiatric History

Has your child ever received any of the following services?
Individual therapy: [ ] No [ ] Yes (please describe, including dates and providers): _____
_____
_____
Family therapy: [ ] No [ ] Yes (please describe, including dates and providers): _____
_____
_____
Group therapy: [ ] No [ ] Yes (please describe, including dates and providers): _____
_____
_____
Psychological testing: [ ] No [ ] Yes (please describe, including dates and providers): _____
_____
_____
Inpatient (Hospital or Residential): [ ] No [ ] Yes (please describe, including dates and providers): _____
_____
_____
Past suicidal ideation? [ ] No [ ] Yes (please describe, number of attempts, when, and how): _____
_____
_____
Current suicidal ideation? [ ] No [ ] Yes (please describe, number of attempts, when, and how): _____
_____
_____
Concerns about aggressive behavior or homicidal ideation/behavior? [ ] No [ ] Yes (please describe): _____
_____
_____
Any previous diagnosis? [ ] No [ ] Yes (please describe): _____
_____
_____

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)
[ ] Other: _____

Mood Stabilizers

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

Anti-Anxiety (Anxiolytics)

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

Atypical Antipsychotics/Mood Stabilizers

[ ] Abilify (aripiprazole)
[ ] Clozaril (clozapine)
[ ] Latuda (lurasidone)
[ ] Zyprexa (olanzapine)
[ ] Seroquel (quetiapine)
[ ] Risperdal (risperidone)
[ ] Geodon (ziprasidone)
[ ] Haldol (haloperidol)
[ ] Prolixin (fluphenazine)
[ ] Other: _____

Typical Antipsychotics

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

Sedatives/Sleep Aides

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

ADHD Medications

[ ] Adderall (amphetamine)
[ ] Adderall XR
[ ] Concerta (methylphenidate)
[ ] Ritalin (methylphenidate)
[ ] Daytrana (methylphenidate)
[ ] Metadate(methylphenidate)
[ ] Evekeo
[ ] Dyanavel XR
[ ] Strattera (atomoxetine)
[ ] Quillivant XR
[ ] Vyvanse (lisdexamfetamine)
[ ] Focalin (dexmethylphenidate)
[ ] Other: _____

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:
[ ] Unmarried/together for: _____ years
[ ] Married for: _____ years
[ ] Separated since child was: _____ years old
Legally divorced? [ ] No [ ] Yes (please describe custody arrangement, including medical decision making): _____
_____
_____
Who is living in the home? (please descried names, ages and relationship to the child): _____
_____
_____

School History

Did your child have to repeat a grade? [ ] No [ ] Yes (please describe): _____
_____
_____

Ever been suspended? [ ] No [ ] Yes (please describe): _____
_____
_____

Is your child requiring special services in school (either an IEP or a 504B plan)? [ ] No [ ] Yes, _____
Is your child in the gifted program? [ ] No [ ] Yes
My child's weakest subject is: _____

Is your child involved in any extra-curricular activities? [ ] No [ ] Yes (please describe): _____
_____
_____

Does your child's teacher(s) have any concerns? [ ] No [ ] Yes (please describe): _____
_____
_____

Has your child ever had other evaluations? (i.e. Psycho-educational, Academic, Speech, Occupational Therapy)
[ ] No [ ] Yes (please describe): _____
_____
_____
_____
_____

Substance Use

Does your child use:
Alcohol? [ ] No [ ] Yes (how often): _____
Recreational Drugs? [ ] No [ ] Yes (how often and what kinds): _____

Habits/Activities of Daily Living

Any concerns around bedtime? [ ] No [ ] Yes (please describe): _____
_____
_____

My child generally sleeps from: _____ to _____

Sleeps independently? [ ] No [ ] Yes (please describe): _____
_____
_____

Any concerns about your child's eating habits/appetite/nutrition? [ ] No [ ] Yes (please describe): _____
_____
_____

Has your child reached menses? [ ] No [ ]Yes [ ] N/A

Is your child dating? [ ] No [ ] Yes [ ] I don't know

Is your child sexually active? [ ] No [ ] Yes [ ] I don't know

Any habits or repetitive behaviors that concern you? [ ] No [ ] Yes (please describe): _____
_____
_____

How would you characterize your child's mood, most of the time? [ ] Good [ ] Fair [ ] Poor

Trauma History

Has your child ever experienced or witnessed any kind of abuse?
[ ] No
[ ] Emotional abuse: _____
[ ] Physical abuse: _____
[ ] Sexual abuse: _____

Other agencies involved (Currently or previously involved with your child/family):
[ ] DCF: _____
[ ] Probation officer: _____
[ ] Other: _____

Psychosocial stressors (Please indicate as many as you believe may impact your child):
[ ] 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 your child/family belong to a religious or spiritual group?
[ ] Prefer not to answer [ ] No [ ] Yes (please describe child's level of involvement): _____
_____
_____

Are there any cultural factors that could impact your child's treatment? [ ] No [ ] Yes (please describe): _____
_____
_____

Does your child have any disabilities that could impact his/her treatment? [ ] No [ ] Yes (please describe):_____
_____
_____

My Child's Interests/Strengths: _____
_____
_____
_____

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

_____ _____
Printed Name of Parent/Guardian Relationship to Patient

_____ _____
Signature of Parent/Guardian Date

General Policies, Insurance Assignments, Financial Agreement, Authorization to Release Information, and Privacy Notice Acknowledgement

Assignment of Insurance Benefits
In consideration of services rendered, I hereby transfer and assign to Elite DNA Therapy Services 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)

Financial Agreement
The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney's fees and collection expense. The undersigned certifies that he/she has read the foregoing, receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms. _____ (initials)

Medicare / Medicaid
Patient's authorization to release information and certification to allow payment. 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 treating me. _____ (initials)

Use of Copies
I permit a copy of these authorizations and assignments to be used in place of the original, which will remain on file at the clinic. _____ (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 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 period of time not to exceed 30 days.*** _____ (initials)

Financial Agreement
It is a patient's responsibility to know his/her insurance coverage for services, as some services and general medical coverage may be provided by two separate plans. Our office staff is happy to help answer questions and help with this process. Patients in poor credit standing with Elite DNA Therapy Services will make their co-payments or payment in full at the time of their visit. We reserve the right to assign unpaid bills to a collection agency. If you have any questions not covered by this statement, please feel free to ask for clarification. The undersigned certifies that he or she has read, understands, and accepts the terms and conditions of this form. The undersigned is either the patient or is duly authorized to sign this form and receive a copy. _____ (initials)

Fees for Clinical Services
At Elite DNA Therapy Services, we accept many of the major 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 the scheduled appointment. _____ (initials)

Missed/Cancelled Appointments
A patient who fails to appear at, or cancels less than 24 hours in advance of, an appointment may be subject to a $75 fee and/or may be discharged from the clinic. Please remember to reschedule ahead of time and we will try our best to accommodate you. Since "things happen," patients will be permitted to miss one appointment without being penalized per 6 months. 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 more than 15 minutes late for their appointment. Please call to let us know if you are running late and we will be happy to reschedule your appointment, as needed. However, you may be subject to a $75 fee or stop of services if you are not able to maintain your appointments. _____ (initials)

Emergency Services (for all therapy services)
For non-life-threatening after-hours services, please call the office and follow the prompts. Please note, **we are not a 24-clinic** and for emergencies call 911 or go to the nearest emergency room. _____ (initials)

Confidentiality and Release of Information
All information disclosed within sessions is confidential and may not be revealed to anyone outside of the Elite DNA Therapy Services without your 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 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. _____ (initials)

_____ _____
Printed Name of Parent/Guardian Relationship to Patient

_____ _____
Signature of Parent/Guardian Date

Preliminary Treatment Plan

Desired Services and long term goals for my child: _____
_____
_____
_____
_____

Short term goals: I will attend the initial assessment at Elite DNA Therapy Services and will follow through with treatment recommendations. I will give input into the assessment and will work with the provider to develop specific ongoing goals.

Goal date: 45 days from today's date

Interventions:
Biopsychosocial evaluation (1x annually)
Treatment plan development (1x annually)
If referred to therapy, individual or family therapy (1x per week, 4 units)
If referred to psychiatry, psychiatry medication management (1x/month)

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Child (if over 6 years old) Date

_____ _____
Signature of Intake Clinician Date

_____ _____
Licensed practitioner signature (if applicable) Date

Authorization to Discuss Health Information

Patient Name: _____ Date of Birth: _____

I hereby authorize Elite DNA Therapy Services to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

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

Indicate Confidential Information:

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

Information to be given to:

Full Name: _____

Address: _____

_____

Phone: _____

Relationship to Patient: _____

This authorization shall remain in effect from the date signed below until (please check one):

[ ] _____ (specify expiration date or event)
[ ] NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting the Privacy Officer.
- This authorization is giving Elite DNA Therapy Services the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization.

_____ _____

Printed Name of Parent/Guardian Relationship to Patient

_____ _____

Signature of Parent/Guardian Date

Summary Notice of Privacy Practices

This is a summary of our Notice of Privacy Practices, which describes how medical information about you may be used and disclosed and how you can get access to this information. By signing this form, the signatory acknowledges an understanding of Elite DNA Therapy Services privacy practices.

Our pledge to protect your privacy:
Elite DNA Therapy Services is committed to protecting the privacy of your medical information. Your care and treatment is recorded in a medical record. So, that we can best meet your medical needs, we share your medical record with the providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

Patient Rights - You have the following rights regarding your medical information:

- to request to inspect and obtain a copy of your medical records, subject to certain limited exceptions;
- to request to add an addendum to or correct your medical record;
- to request an accounting of Elite DNA Therapy Services' disclosures of your medical information;
- to request restrictions on certain uses or disclosures of your medical information;
- to request that we communicate with you in a certain way or at a certain location;
- and to receive a copy of the full version of our Notice of Privacy Practices.

We may use and disclose medical information about you for the following purposes:

- to provide you with medical treatment and services;
- to bill and receive payment for the treatment and services you receive;
- for functions, necessary to run Elite DNA Therapy Services, and assure that our patients receive quality care;
- to provide basic contact information (no medical information is provided) to our Administrative office for purposes contacting patients about events and new services;
- to support our standing as an AHCA qualified health center;
- and as required or permitted by law.

There are additional situations where we may disclose medical information about you without your authorization, such as:

- for workers' compensation or similar programs;
- for public health activities (e.g., reporting abuse or reactions to medications);
- to a health oversight agency, such as the Florida Department of Health;
- in response to a court or administrative order, subpoena, warrant or similar process;
- to law enforcement officials in certain limited circumstances;
- to a coroner, medical examiner or funeral director; and
- to organizations that handle organ, eye, or tissue procurement or transplantation.

Our Notice may be revised or updated from time to time. Please see our full Notice of Privacy Practices for a more detailed description of our privacy practices, your rights regarding your medical information, and pertinent contact information.

For further information about the full Notice of Privacy Practices, please contact: Elite DNA Therapy Services, LLC's Privacy Officer at (239) 223-2751 or privacy@elitednatherapy.com.

Printed Name of Parent/Guardian	Relationship to Patient
Signature of Parent/Guardian	Date

Addendum I: Consent for Treatment of Minor Patient

Patient Name: _____ Date of Birth: _____

I (full name) _____, verify that I am the legal guardian for the minor patient named above and furthermore certify that the information, records and other documents I have provided to DNA Comprehensive Therapy Services (dba: Elite DNA Therapy Services) (either verbally or in writing) are accurate to the best of my knowledge.

Initial: _____ I give permission to Elite DNA Therapy Services to provide medical treatment and services for my child, including but not limited to: medication management, psychotherapy, speech therapy and occupational therapy, all within the professional medical judgement and discretion of Elite DNA Therapy Services' doctors, nurse practitioners, and staff. I understand that before Elite DNA Therapy Services will perform medication management services, I must sign an additional, separate medication consent document and that no prescriptions will be provided without the written medication consent signed by me. I understand Elite DNA Therapy Services will not complete medication changes (including the prescribing of new medications or the termination of any current prescriptions), unless and until the minor has been personally and thoroughly evaluated. In rare, emergency circumstances, medication changes requirements may be excepted, in accordance, with the medical and professional judgement of Elite DNA Therapy Services.

Initial: _____ I hereby verify that presently, there are no issues in dispute with regard to the parental or legal custody of minor patient named above and agree that it is my responsibility to inform any other legal guardians that the minor patient will be receiving the services described herein. I am fully aware that if at any point during treatment there is any change in the custody status of minor patient, I am obligated to immediately inform Elite DNA Therapy Services in writing.

Initial: _____ I agree to fully participate in treatment of my child and cooperate with the Elite DNA Therapy Services treatment team, including providing appropriate legal documentation as necessary. I understand and agree that it is my obligation to communicate all important information to other legal guardians, including the dates/times of appointments, medication management changes and other information that may be communicated to me. I understand that any legal guardian has the right, unless otherwise determined by a court of law, to attend appointments at Elite DNA Therapy Services and have direct involvement and/or participation in treatment to be determined by the Elite DNA Therapy Services treatment team. I understand and agree that if the lack of cooperation and/or participation of the minor patient's legal guardians, or if custody issues or disputes, are hindering or otherwise preventing appropriate treatment of the minor patient, treatment and services may be suspended or terminated at the sole discretion of Elite DNA Therapy Services. I understand if any information provided to Elite DNA Therapy Services has been misrepresented or if important changes to information are not timely communicated to Elite DNA Therapy Services, such misrepresentations or failures to disclose may also result in suspension or termination of services.

Initial: _____ I understand that all legal guardians have the right to obtain minor patients medical records upon request; however, if there are any conflicts, disputes, legal ramifications, or authorization issues regarding the release of medical records, or in the medical and professional judgement of Elite DNA Therapy Services, the minor patient is best served or protected by having the medical withheld, Elite DNA Therapy Services may withhold release of such records on behalf of the minor, with any release to be determined by an appropriate court of Law. In such a situation, Elite DNA Therapy Services is asserting the psychotherapist-patient privilege on behalf of the minor patient pursuant to Florida Statutes § 90.503(3).

_____ _____

Printed Name of Parent/Guardian Relationship to Patient

_____ _____

Signature of Parent/Guardian Date

Addendum II: Authorization for Other Individuals to Accompany the Minor Patient

Patient Name: _____ Date of Birth: _____

Initial: _____ I understand and agree that I am not required to authorize any other individual to present or accompany the minor patient to Elite DNA Therapy Services. However, by completing this authorization, I am voluntarily giving consent for the individual(s) named below to bring the minor patient to Elite DNA Therapy Services for rendering of the services described in the Consent Agreement to which this Addendum is attached and shall become incorporated herein.

Initial: _____ I fully understand for psychiatric appointments no medication changes will be completed without my written approval in the form of a signed Medication Management Consent (Addendum I) and that the individual(s) named below shall not have the authority or consent to sign an updated Addendum I. I have been informed that professional judgement Elite DNA Therapy Services will be exercised regarding any changes in treatment when the minor patient is accompanied by one of the authorized alternative individuals below to whom I give my authorization and consent to accompany the minor patient.

Initial: _____ I understand and agree that my authorization and consent for alternative individual(s) to participate and accompany the minor patient to Elite DNA Therapy Services should only be sporadic and not a regular occurrence. I, likewise, understand and agree that my authorization and consent does not replace my responsibility for cooperation and involvement in the treatment of the minor patient as outlined and agreed to by signing the Consent for Treatment to which this addendum is attached and shall become incorporated herein.

Initial: _____ 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 the minor patient. Individuals with any relationship to the minor patient other than those described in the preceding sentence shall not be named below.

Initial: _____ I understand that I may revoke the consent of either or both individual(s) listed below at any time. By signing this authorization, I certify that I have had the opportunity to consider this agreement and present it to my attorney for review and hereby assert that I have done so or otherwise waive my right to do so.

I hereby authorize the following additional individual(s) to serve as my agent for purposes of accompanying my child to appointments at Elite DNA Therapy Services:

Full Name: _____

Address: _____

_____

DOB: _____

Relationship to Patient: _____

Full Name: _____

Address: _____

_____

DOB: _____

Relationship to Patient: _____

_____ _____

Printed Name of Parent/Guardian Relationship to Patient

_____ _____

Signature of Parent/Guardian Date

Addendum III: Explanation of Custody Dispute and Authorization of Legal Guardians

Patient Name: _____ Date of Birth: _____

Initial: _____ By completing this Addendum III, I certify that there is an ongoing custody dispute and/or custody considerations are not final and a court order on custody has not been issued. However, as legal guardian of the minor patient name in the Consent for Treatment to which this Addendum is attached and shall become incorporated herein, I authorize Elite DNA Therapy Services to provide the services to the minor patient as outlined therein, with the understanding that it is my responsibility to inform any other legal guardians that the minor patient will be receiving the services described herein.

Initial: _____ I understand and agree that if at any point during treatment there is any change in the custody status of minor patient, I am obligated to immediately inform Elite DNA Therapy Services in writing.

Initial: _____ I understand and agree that if the lack of cooperation and /or participation of the minor patient's legal guardians or if custody issues or disputes are hindering or otherwise preventing the appropriate treatment of the minor patient, treatment and services may be suspended or terminated by authorize Elite DNA Therapy Services at its sole discretion.

Initial: _____ I understand and agree that it shall be within the medical and professional judgement and discretion of authorize Elite DNA Therapy Services to provide services outlined herein. However, I understand and agree that by consenting to the minor patient's treatment, it is my responsibility to put the emotional and mental health needs of the minor patient before any custody or legal complications, and agree I will fully cooperate and participate in the minor patient's treatment, and likewise will encourage any other legal guardian to cooperate and participate to the extent it is appropriate and legally permissible to do so.

Please briefly explain why the custody situation for the minor patient is not fully resolved at this time: _____
_____
_____
_____
_____

Please attach legible copies of relevant court or legal documents that indicate the terms of a custody agreement and identify those documents.

_____ _____
Printed Name of Parent/Guardian Relationship to Patient

_____ _____
Signature of Parent/Guardian Date

If an additional legal guardian is also consenting to the treatment of the minor patient, please sign below.

_____ _____
Printed Name of Parent/Guardian Relationship to Patient

_____ _____
Signature of Parent/Guardian Date