



Welcome to FUNctionabilities<sup>1</sup>. We are excited to help your child learn to play and play to learn. Thank you for choosing us to provide therapy services for your child! Our therapists bring professional knowledge and expertise to every session to help your child progress with his/her individualized goals. Our highly-qualified therapists utilize the best, evidence-based methods to ensure your child has fun while gaining or refining skills to improve function in everyday life.

### **What can I expect at the evaluation?**

At FUNctionabilities we promote a safe, healthy, fun environment beginning with removing shoes and wearing clean socks prior to treatment to maintain a clean therapy gym and maximize sensory input during treatment. During the evaluation, the therapist will meet with you to better ascertain your concerns and then utilize assessment tools with your child such as: games, activities, observations, interviews, and written work to better understand the core problems and provide the most advanced, productive therapy possible. A typical evaluation lasts 45-60 minutes for speech therapy and 45-90 minutes for occupational therapy; unless you desire a more comprehensive assessment. Your child's age and ability to attend to these activities play a role in how long it takes to complete our evaluations. While the therapist and your child are completing testing, the care coordinator and/or the therapy liaison will present three options for assessments to you in the lobby based upon the complexity of your child's condition, the goals you want to achieve, and the clinical observations that the therapist has completed. The difference between the three options is the more testing we can do up front the better we can pinpoint all the areas that are affecting your child; however, no matter what you choose we are able to gather information throughout treatment sessions and adjust plans of care accordingly, it just requires more time.

The cost of your child's highly individualized evaluation depends on your choice of Good, Better, or Best evaluation and will be reviewed with you so that the therapist can complete the evaluation. It is your responsibility to understand what your policy covers and pays before the time of service; for anything that is not covered by insurance (see page 6). These days there is typically a portion of therapy services for which you are responsible. We do not like to give you unexpected bills so please be familiar with your health coverage. Once the payment method is determined and the evaluation has been completed, it's time to turn up the level of FUN and begin treatments. Our treatments will help your child to make changes and increase the success your child has in everyday life. Don't worry about the payment; we have several convenient payment options to make your child's care more affordable.

### **What should I expect during therapy sessions?**

At the first therapy session after the evaluation is completed, the therapist will pick up your child in the lobby and our staff will bring you the evaluation to review, along with your child's Hero Exercise Program (HEP) packet. Please bring this folder with you to appointments to keep all your child's HEP and reports together. The therapist will leave the gym early to answer any questions you might have and confirm that the specified goals address your concerns before we deliver it to your doctor. They will show you a treatment plan based on these findings. To help reach these goals and improve interactions at home, therapists may provide verbal instruction, written home programs, and/or physical adaptations to assist in building your child's skills and mastery of their goals. When these suggestions are carried out throughout the week at home your child has more opportunities for developmental progression. If you ever have questions regarding these suggestions, please ask your therapist at the next visit.

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<sup>1</sup> FUNctionabilities was a DBA of Absolute Kare Therapy, Inc., a Utah corporation but is now a Utah corporation of its own.

Sometimes the therapist that completed the evaluation will not provide the treatment sessions or it may be necessary for another staff member to fill in. Don't worry if this happens, ALL the staff at FUNctionabilities are trained and highly qualified. Therapy begins at the front door and continues through clean up and transitioning back to the lobby.

Most of the time getting the kids to leave the fun therapy activities is the hardest part; but it's a necessary part of what we do. Parents or guardians are required to be on the premises during therapy, you can enjoy a movie or magazine while you wait. We need the parent around so we can discuss: home programming, your child's successes, and/or to help you know how to assist your child until the next visit.

### **How long does a therapy session last?**

- Speech therapy = 30-minute sessions: 23 minutes with your child; 7 minutes of preparation, clean up, and consultation.
- Occupational therapy = 45-minute sessions: 38 minutes with your child; 7 minutes of preparation, clean up, and consultation.

Don't worry if it appears all your child is doing is playing. That's the secret ingredient to your child's success in therapy and daily life. When your child is motivated and having fun, he/she is more able to learn, grow, and reach his/her goals. We assure you our staff is choosing the perfect activities to best assist your child in reaching his/her goals. Our therapists use experience and training to make changes to activities during treatment sessions to improve your child's success.

We run on time so please arrive a few minutes early to avoid a \$25 appointment late fee. We are required to report the exact time we are with you and your child and are reimbursed accordingly. This means when you are late it affects both your child and our clinic. Let us know at least 48 hours in advance if you need to cancel or change an appointment to avoid a \$40 cancellation fee. Remember cancellations delay the work we do with your child and extend the time it takes to get results. NO SHOWS ARE BAD. Because it is important to provide treatment to every child that needs our services, we charge a \$50 fee per no-show. A no-show could mean we will no longer provide services to your child or will only offer you last minute, first-come, first-serve appointments. We are required to document all cancellations and missed visits in your medical record and report it to your physician and insurance company/third party payer. If you accumulate three cancelled or missed visits, your therapist may have to refer you back to your physician before scheduling another appointment. We do NOT like to charge fees so please be on time and schedule appointments you know you can make. We have many children waiting to be seen so it is critical that you remember your appointment and arrive on time. Our priority is to help children progress quickly, so they can be discharged and live a successful life.

### **How long will my child need therapy?**

Each child varies depending upon the complexity of their condition and the goals that you wish to achieve with your child. Most children need 6-12 months of therapy; while other children require multiple years due to significant developmental delays. The therapist will show you our program pathway and how your child's journey will move along in this pathway. When your child has met his/her goals at 80% we will re-evaluate to either: 1) update the plan of care with new goals and continue therapy or 2) prepare for discharge. Discharge is an exciting and special occasion that we love to celebrate with you and your child. It gives the child a sense of accomplishment and allows the team to provide your child with a gift to celebrate his/her hard work and success.

### **Referral Appreciation:**

We are a small business and recognize we need your support to continue to grow. We appreciate you writing reviews and telling your friends and family about us. You will receive a gift card when we evaluate someone that you referred to us.

### **One last thing:**

Look us up on social media. We frequently post helpful resources that will further enhance your child's progress. Tell people about your child's success and celebrate with us on social media. You can visit our website: [www.makingtherapyfun.com](http://www.makingtherapyfun.com) for more information about what we do and for more resources.

Thank you for being an important part of your child's team!

## 1. Personal Info

Please fill out entire form completely and legibly. ALL INFO REQUIRED in order to bill insurance

Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F Diagnosis: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Location: \_\_\_\_\_ Dr. Phone #: \_\_\_\_\_

Names of professionals working with my child: \_\_\_\_\_

Mother's / Guardian Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father's / Guardian Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Who does the child live with most of the time? \_\_\_\_\_ Home Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Emergency Contact Name & Phone: \_\_\_\_\_

If applicable, Foster/Adopt Info:  Placed in our home for foster care at the age of \_\_\_\_\_ on \_\_\_\_\_ mo/\_\_\_\_ yr Number of previous placements \_\_\_\_\_

Formally adopted by us at the age of \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous names child has had prior to adoption: \_\_\_\_\_

## 2. Child Info

Are there any precautions the therapist should be aware of when working with your child?  No  Yes If yes, when and what:

What are your primary concerns regarding your child's development?

In one year it would be amazing if my child could.....

What do you see as your child's strengths?

In one sentence, how would you describe your child?

School/Grade/Teacher/Services at school:

Assistive Devices: \_\_\_\_\_

## 3. Payment Info

(Check only one box)

I am paying TODAY by....

**INSURANCE** and would like to...

\_\_\_\_ Have you deal directly with them. I will assign my benefits to you by completing the "Assignment of Benefits Form" (see p.7) Fees may apply in some cases if not filled out completely and correctly.

\_\_\_\_ Get a 15% discount by paying the entire bill at the time of service. I'll get reimbursement on my own.

**CASH or CREDIT** and would like a ...

\_\_\_\_ 15% discount for paying the entire bill at the time of service.

\_\_\_\_ Discount of up to 40% for a package

\_\_\_\_ Payment plan or apply for "Financial Hardship"

## 4. Parent Permission

(Please initial each item and sign below)

**1. AUTHORIZATION OF SERVICES:** I give my consent for my child to receive services provided by FUNctionabilities in the clinic, my home, and in the community with parent / guardian present. \_\_\_\_ **(initial)**

**2. RELEASE OF INFORMATION:** I authorize the exchange of information between FUNctionabilities, physician's offices, therapy providers, insurances, and school records as they apply to the provision of therapies. \_\_\_\_ **(initial)**

**3. PHOTO CONSENT:** I hereby authorize FUNctionabilities to photograph/ videotape my child for the purpose of:

a. Documenting my child's therapy \_\_\_\_ **(initial)**

b. Publications or educational programs Yes \_\_\_\_ No \_\_\_\_ **(initial)**

c. Promotional ads for FUNctionabilities Yes \_\_\_\_ No \_\_\_\_ **(initial)**

**4. OBSERVATION CONSENT:** I understand that FUNctionabilities is a teaching facility and I hereby give permission for students to participate in and observe my child's therapy. \_\_\_\_ **(initial)**

**5. PARENT PROXY:** I understand that if another adult accompanies my child to therapy I am authorizing information to be released to that adult. \_\_\_\_ **(initial)**

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 5. Referral Info

How did you hear about us?

- Brochure                       Friend or Family  
 Internet                         Physician/Dentist/Chiropractor/Nurse  
 Advertisement              Name \_\_\_\_\_  
 Insurance/Directory        Phone \_\_\_\_\_  
 Other \_\_\_\_\_

## Important Company Policies for a Successful Relationship

We strive to provide your child the best personalized care available. To make this possible, we adhere to very important policies. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom of page 3.

Initial All Boxes

**Late Policy:** We have a strict late policy because we try so hard to run on time; if you arrive after the appointment time you will be charged a **\$25 late appointment fee**. Remember, insurances only reimburse us for face-to-face time with your child so if you are not here on time both your child and our clinic lose out. We reserve the right if you are more than 10 minutes late, to require you to reschedule or wait for the next opening and/or charge a cancellation fee. There are no guarantees since cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient so please be early for your appointment.

**48-Hour Advance Notice Policy:** If you wish to change or cancel an appointment, we require a minimum **48-hour advance notice**. Anything less will result in a **\$40 cancellation fee** charged to your account. Whether you attend or not it costs us money to make appointments available to you (for staff wages, rent, etc.). We do not make money with this charge; the fee is to act as a deterrent from making last minute changes. Advance notice allows another child in need time to reserve an appointment in place of your child's. Please be courteous and responsible. Thank you.

**No-Shows: No-shows are bad.** If you fail to show for an appointment without notice, all future appointments will be cancelled, and a **\$50 fee** will be assessed to your account. **If there are 2 no shows within 90 days, we will no longer provide services to your child** allowing us to provide services to another child who needs therapy. We reserve the right to discontinue services under any circumstance as we may elect at our sole discretion.

**Child-Centered Policy:** We believe firmly in a child-centered model of treatment and contribute our results to this focus. This model allows us to focus on the child and grants you a break while waiting in the lobby from the difficult job you have as parent.

**Minors and Parents:** If a patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on the premises or not, and it is the responsibility of the parent or guardian to supervise the minor before and after treatments. You should be available during the session if needed. Should any of your children be left unattended before, during, or after a session you will incur at least a **\$15 fee** since this requires a member of our team to sit with your child at the expense of leaving their regular duties.

**Patient Declaration:** The therapist explained to me the type of treatments ideal for my child's condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form. I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my informed consent for the therapist to render treatments to my child.

**Treatment Time:** Please be cognizant of the time you spend with our therapists and if you require more time please set up an appointment so that we don't take away time set aside for your child or someone else's child. Consultation can include preparation for IEPs, 504s, or other in-depth questions. Remember therapy sessions are 45 minutes and 30 minutes as laid out in the Welcome Letter. When you respect our time by setting up an appointment to further discuss your child's needs, we will give you a 50% discount off our consultation fee.

**Consultation Policy:** We want to spend every moment possible with your child. And while we do believe that your involvement and education is critical to your child's success; insurances do not pay for us to consult with you. We have set aside a few minutes to discuss your child's care with you and we will continue to provide homework to facilitate your child's care. Parent Consultation Fee: starts at \$50 for 15 minutes.

**Results:** The purpose of occupational / speech / physical therapy is to maximize your child's body's own healing potential through natural means and to promote their ability to perform daily, play, leisure, social, and sports activities through increased self-regulation, motor planning, strength, and movement strategies. It is not possible to predict the results or outcomes of treatment. Typically, benefits are realized gradually over time. Each case is unique and FUNCTIONabilities makes no representations or warranties regarding results of therapy provided.

**Informed Consent:** By signing page 3, the parent or guardian represents and warrants that they are authorized to sign and hereby gives the therapist permission for the evaluation and treatment of the child. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your child's care, be sure to ask the therapist. It is up to the parent/guardian to inform the therapist/staff about any health problems or allergies the child may have. The parent/ guardian must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or previous or planned surgeries. Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

**Important Notice from the Federal Government:** "It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments... even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan, even if your doctor allows it. You may both be charged with breaking the law. This includes services deemed as "professional courtesy" and TWIP's - take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A (a)(5) of the Health Insurance Portability and Accountability Act of 1996 (section 231(h) of HIPAA). Exceptional cases do apply. Please see contact info for more information: Office of Inspector General, Department of Health and Human Services. Contact by phone: 202-619-1343, by fax 202-260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Dept. of Health and Human Services, Room 5541 Cohen Building 333 Independence Ave, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202-619-0089."

***We look forward to building a relationship with you that will last a lifetime!***





## Credit Card on File Authorization Form

Nothing will be charged unless a balance is due. Your payment will be automatically charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started! This form is mandatory and must be filled out prior to the evaluation.

**Credit Card on File Will Make Your Life Easier:**

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

**Here's How Credit Card on File Works:**

You authorize regularly scheduled charges to your credit card for any patient responsibility, including standard co-pays, remaining balance, payment plans, appointment fees, and no-show fees. Nothing will be charged unless a balance is due. A receipt for each payment will be emailed to you. You agree that no prior-notification will be provided. You understand that FUNctionabilities is utilizing the latest standards in card data security and HIPAA compliance. Card data being stored is encrypted and tokenized and stored off-site in a secure vault trusted by many fortune 500 companies.

**Please complete the information below:**

I \_\_\_\_\_ authorize FUNctionabilities to charge my credit card to satisfy my financial obligations as defined by FUNctionabilities Payment Agreement.

Billing Address \_\_\_\_\_ Phone# \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Email \_\_\_\_\_

**Debit / Credit Card**

- |                               |                                     |  |
|-------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Visa | <input type="checkbox"/> MasterCard | <b>* Swipe or key card into merchant card services to save</b> |
| <input type="checkbox"/> Amex | <input type="checkbox"/> Discover   |  |

Cardholder Name \_\_\_\_\_

Last 4 digits \_\_\_\_\_ Exp. Date \_\_\_\_\_

I understand that I can update my card information on file at any time by contacting our office directly. In fact, it is my responsibility to notify FUNctionabilities of any updates or changes to the credit card on file associated with this agreement as soon as possible. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I certify that I am an authorized user of this debit / credit card and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

## Assignment of My Benefits

IMPORTANT: All information must be **completed**, or we will **NOT** be able to deal directly with your insurance.

**BENEFIT INFO:** Call the "800" number on your insurance card and ask the following questions:

What is your deductible amount? \$ \_\_\_\_\_ and Copay \$ \_\_\_\_\_ or Coinsurance % \_\_\_\_\_ for occupational therapy/speech therapy/physical therapy. Are there any exclusions on your plan concerning these services? \_\_\_\_\_  
 How many visits are you allowed for these services? \_\_\_\_\_ Is this per calendar year or from what date? \_\_\_\_\_  
 Do your benefits require preauthorization or clinical submission? Y / N Ask for a call reference number: \_\_\_\_\_

**PATIENT INFO:** Patient Name: \_\_\_\_\_ ID # \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Policy: \_\_\_\_\_ Group # (if applicable) \_\_\_\_\_

**\*\*IS PATIENT INSURED THROUGH SOMEONE ELSE'S POLICY?** Relationship to Patient: Parent/Guardian, Other: \_\_\_\_\_

- Policyholder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

- Address (if different than Patient) \_\_\_\_\_

Insurance Policy #2: Name/Number/Group # (if applicable) \_\_\_\_\_

- Policyholder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

- Address (if different than Patient) \_\_\_\_\_

- Relationship to Patient: \_\_\_\_\_ Parent/Guardian \_\_\_\_\_ Other: \_\_\_\_\_

I hereby instruct and direct my insurance company to **pay by check made out to the "Healthcare Provider" to the right and mailed to** the address on the right (not mine). If my current policy prohibits direct payment to doctor/ therapist, I hereby also instruct and direct you to make the check payable to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. I will promptly upon receipt sign over all checks pertaining to services here.

Healthcare Provider Info:  
**FUNctionabilities**  
**PO Box 363**  
**Riverton, UT 84065**

**Medical Necessity**

All treatments must be justified and medically necessary for us to treat and bill your insurance. Some factors that determine if treatment is medically necessary are:

1. Does your child's condition interfere with the quality of his/her life?
2. Does your child's condition interfere with his/her ability to perform typical tasks or daily activities?
3. Are you motivated and able to help your child participate in our treatment program and follow home and self-care instruction?
4. Is there potential for your child's condition to improve and/or resolve? If not, is there potential for your child's function or ability to perform daily activities to improve through modified movement, assistive devices, etc.? If not, is there potential for your child's condition to cause him/her to regress without intervention?
5. Are there specific goals set that are measurable and trackable?

**This is a direct assignment of my rights and benefits under this policy.**

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. **(Check each box and sign at the bottom)**

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize the "Healthcare Provider" named above to deposit checks made in my name.
- I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner or file an appeal for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
 Signature of Policyholder

\_\_\_\_\_  
 Witness

\_\_\_\_\_  
 Signature of Claimant, if other than Policyholder

## NOTICE OF PRIVACY POLICIES

*Effective June 1, 2015*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners. We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us at **(801) 443-7775 extension 3**. Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer. If our Privacy Officer is not available, you may make an appointment for a conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide FUNctionabilities with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

\_\_\_\_\_  
Parent's Name (print)

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date