Cornerstone
BEHAVIORAL HEALTH
PEDIATRIC THERAPIES

Structured Intake Questionnaire

Today's Date: _____

The information you provide will help staff determine the care your child needs as well as any further assessments. A patient's individual background, cultural and family surroundings are important factors in her or his response to illness and treatment. Your thoroughness is critical to your child's evaluation.

Please use back of paper if you need more space for responses

Demographic Information:

Patient's Name:_____ Date of Birth: ____/____/____

Caregiver Name(s):_____

☐ Parent ☐ Step-Parent ☐ Legal Guardian ☐ Foster Parent ☐
Other_____

Please note dates and circumstances related to any change in custody of this child:

_____

Home Address: _____ City:_____ Zip:_____

Primary Phone: ☐ _____ Secondary Phone: ☐ _____Check preferred number

E-mail Address: _____

Child's Race/Ethnicity: _____

Child's home language: _____

Does your child receive Social Security Income? ☐ Yes ☐ No

Referral Source: _____

Please list all persons currently residing with the patient: _____

_____

General Information:

What are the presenting concerns that brought you in for an evaluation? (Please describe the major concerns and / or goals you have in seeking help for your child) List your concerns in order of their importance to you.

_____

_____

_____

_____

At what age were you first concerned about your child's development? _____

Briefly describe earliest signs of concern:_____

Medical Background:

Pregnancy and Birth History:

Were there any complications during pregnancy with your child? ☐ YES ☐ NO

If yes, please explain: _____

_____

Were there any complications of the birth/delivery of this child? ☐ YES ☐ NO

Please circle all that apply:

Breathing/Respiratory problems	Jaundice	Hypoglycemia	Fetal distress
Failure to thrive	Feeding difficulties	Low birth weight	

Genetic condition: _____Other: _____

Gestational age at time of delivery (or #weeks early/late):_____

Birth Weight: _____ Length: _____

Was your child in the NICU? ☐ YES ☐ NO

If so, how long and please describe: _____

_____

Were there any additional complications during your child's first year of life? ☐ YES ☐ NO

If so, please describe: _____

_____

Health History:

It is very important to have as complete of a medical history for your child as possible. Please fill out the grid below making sure to include an explanation for any question answered "yes". In your explanation please include your child's age(s) at which the event occurred, any diagnoses made and any treatments which occurred.

NO	YES	DESCRIPTION	EXPLANATION
		Frequent colds/respiratory illness	
		Frequent strep throat/sore throat	
		Frequent ear infections (tubes)	
		Birth defects/genetic disorder	
		Lung condition/respiratory disorder	
		Allergies or asthma	
		Heart condition	
		Anemia/blood disorder	
		Kidney/renal disorder	
		Urinary problems/infections	
		Hormone Problems	
		Muscle disorder/problems	
		Joint/bone problems, fractures (x-rays)	
		Skin disorder/skin problems (eczema)	
		Visual disorder/vision problems	

NO	YES	DESCRIPTION	EXPLANATION
		Neurological disorder	
		Seizures or convulsions	
		Stomach disorder/ stomach pain	
		Vomiting/digestion problems	
		Failure to gain weight/feeding problems	
		Constipation/diarrhea problems	
		Dehydration episodes	
		Hearing loss/ear disorder	
		Significant accidents, head injuries, concussions	
		Ingestion of toxins, poisons, foreign objects	
		MRI/CAT scan	
		Chronic medications (for what? when?)	
		Major childhood illness (pox, coup, measles, mumps, meningitis, etc.)	

Hospitalizations/Surgeries including approximate dates:

_____

_____

Has your child had any difficulties with feeding (i.e., sucking, swallowing, drooling, chewing, choking)?

☐ YES ☐ NO

If so, please describe: _____

Does your child have intolerances or dislikes of major food groups such as grains, fruits, starches, milk, protein, etc? ☐ YES ☐ NO If so, please describe_____

_____

List your child's previous medical, psychological, and/or mental health diagnoses:

Diagnosis	Date	Professional's Name, Title, and Contact Information

Is there a history of learning problems, psychological problems, or mental health diagnoses in your family?

☐ YES ☐ NO

If so, please describe:

_____

List medications your child is currently taking (prescribed and/or over the counter) Do not include medications for acute illness (e.g. Z-pack, antibiotics, etc.):

Medication	Start Date	End Date	Dose	Reason Prescribed	Reason Discontinued

Any additional information regarding medications: _____
Is your child ALLERGIC to any foods or medications? ☐ YES ☐ NO
If so, please identify allergy and exposure response:_____
_____

Date of most recent hearing and vision exams/screen:

Vision_____ ☐ Pass ☐ Fail Hearing:_____ ☐ Pass ☐ Fail

Does your child use any special equipment for daily activities, such as:

Glasses _____ Hearing Aid _____ Splints _____ Wheelchair _____ Other:_____

Primary Care Physician and Contact Information: _____

Has the patient's (circle: **physician** or **teacher**) identified any concerns? ☐ YES ☐ NO
If yes, please provide a brief description:
_____
_____
_____

Social/Emotional/Behavioral:

Regarding your child's personality, what do you like most about your child?
_____
_____
What is most challenging about raising your child?
_____
_____
Do you have any concerns about your child's social interactions with peers (same aged peers)?
☐ YES ☐ NO
If so, please provide a brief description:
_____
_____

Do you have any concerns about your child's behavior? ☐ YES ☐ NO

If so, which of the following apply: Hyperactive Inattentive Aggressive Defiant Disruptive Low Motivation

Please provide details: _____

_____

Do you have any concerns about your child's emotional functioning? ☐ YES ☐ NO

If yes, which of the following apply: Sad Withdrawn Angry Anxious Nervous Inflexible

Please provide details: _____

_____

Has your child experienced any recent stressful events or past events that are still troubling for your child?

☐ YES ☐ NO

Please provide details (noting any history of abuse or trauma):

_____

_____

Who manages discipline of your child at home? What strategies are used and how effective have they been?

_____

_____

What are your child's interests and hobbies? _____

_____

Has your child had problems with any of the following **beyond** expected for child's age?

NO	YES	DESCRIPTION	EXPLANATION
		Sleeping problems	
		Bed wetting	
		Temper tantrums	
		Head banging	
		Breath holding or other self injury	
		Aggression	
		Nervous habits (nail biting etc.)	
		Fire play or destruction of property	
		Cruelty to animals	
		Major mood swings	
		Under or over reactive to sounds	
		Under or over reactive to clothing	
		Under or over reactive to taste	
		Under or over reactive to smell	
		Under or over reactive to pain	

NO	YES	DESCRIPTION	EXPLANATION
		Unusual or extreme fears?	
		Unusual body movements	
		Over reactive to change in routine	

Educational:

Is your child in daycare or school? ☐ YES ☐ NO If so, where? _____What grade? _____

How many total schools has your child attended? _____ Locations? _____

Has your child ever repeated a grade? ☐ YES ☐ NO If so, which grade(s)?_____

Has your child ever been evaluated for special education or for a gifted program? ☐ YES ☐ NO

If so, please describe:_____

Does your child currently have an IEP or 504 Plan in place at school? YES NO (If yes, please provide any information known about when services began, what services are provided, and your child's qualifying disability category): _____

_____

How would you rate your child's overall current intelligence compared to other children?_____

Do you have any concerns about your child's ability to learn or perform on school work? ☐ YES ☐ NO

If so, please describe: _____

Have you noticed any recent changes in your child's academic or behavioral performance? ☐ YES ☐ NO

If so, please describe: _____

Service History

Provider Type	Professional's Name, Title, and Contact Information	Start Date	End Date
Occupational Therapy			
Physical Therapy			
Speech Therapy			
Psychologist/Counselor			
Other			

Developmental History: Did your child experience any delays in the development of early childhood milestones?

Speech/Language milestones (e.g. saying single words, using sentences)? ☐ YES ☐ NO

If so, please describe: _____

_____

Gross or fine motor milestones (e.g. crawling, walking, coloring)? ☐ YES ☐ NO

If so, please describe: _____

_____

Social development (e.g. approaching peers, engaging in interactive play)? ☐ YES ☐ NO
If yes, please describe: _____
_____

Early academic/learning (e.g. identifying colors, numbers/letters, writing name)? ☐ YES ☐ NO
If yes, please describe: _____
_____

Please list any other concerns or information that we should know about your child:

_____
_____
_____
_____
_____
_____
_____

What would you like to happen as the result of your child's evaluation?

_____
_____
_____
_____

Parent/Guardian Signature: _____ Date: _____

Cornerstone Behavioral Health and Pediatric Therapies, Inc.

NOTICE OF PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THE FOLLOWING CAREFULLY.

If you have any questions about this notice please contact Carolyn Donaghey at Cornerstone Behavioral Health and Pediatric Therapies at (405) 455-6868 or by email at office@cornerstoneok.org

This Notice of Privacy Practices describes how Cornerstone Behavioral Health and Pediatric Therapies may use and disclose your protected health information to carry out treatment, payment or health care operations as well as other purposes permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographic information that may identify you and that relates to your past, present or future physical, mental health and related health care services.

Cornerstone Behavioral Health and Pediatric Therapies is required to abide by the terms of this Notice of Privacy Practices. Cornerstone Behavioral Health and Pediatric Therapies may change the terms of this notice at any time. The new notice will be effective for all protected health information maintained at that time. You may request a revised version of Privacy Practices by accessing our website or calling the office and requesting a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF HEALTH INFORMATION:

Treatment: Information about you may be used by the personnel (including students in the field of speech-language pathology who are completing extern placements) associated with Cornerstone Behavioral Health and Pediatric Therapies for diagnosis, treatment planning and treatment. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client, the client's legal guardian or personal representative. It is the policy of Cornerstone Behavioral Health and Pediatric Therapies to release private health information to clients or the parents/guardians of clients who are minors. Should Cornerstone Behavioral Health and Pediatric Therapies need to send information to another professional, a signed Release of Information form is required.

Payment: Cornerstone Behavioral Health and Pediatric Therapies bills directly to your insurance company. You will be given a Notification of Benefits and Financial Responsibility form. You will be responsible for all services rendered which are not covered by your insurance as well as pay any co-payments and/or co-insurance amounts required.

Cornerstone Behavioral Health and Pediatric Therapies will communicate with you only in forms of communication provided on the Contact Information form you completed prior to starting therapy. It is the client's responsibility to update contact information with Cornerstone Behavioral Health and Pediatric Therapies.

OTHER DISCLOSURES: Cornerstone Behavioral Health and Pediatric Therapies may use or disclose your protected health information in certain situations without your authorization or providing you the opportunity to agree or object. Some of these situations include:

Required By Law: We may use or disclose your protected health information to the extent which the use or disclosure is required by 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, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority which is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading

the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law including audits, investigations and inspections. Oversight agencies seeking this information include government agencies which oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, reporting adverse events, product defects or problems, biologic product deviations, tracking products, enabling product recalls, making repairs/replacements or conducting post marketing surveillance as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification

and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Research: We may disclose your protected health 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 protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

YOUR RIGHTS:

You have the right to inspect and copy your protected health information. Meaning you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. Copies can be obtained for $.25 a page from our office.

Under federal law, however, you may not inspect or copy records related to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. Depending on the circumstances, a decision to deny access may be reviewable.

You have the right to revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You have the right to request that information about you be communicated by other means or to another location.

You have the right to disagree with the medical records in our files and you may request this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement which will be placed in your file.

COMPLAINTS: If you believe your rights have been violated by Cornerstone Behavioral Health and Pediatric Therapies please bring the problem our attention first, your concerns will be addressed in a timely manner. If you are not satisfied with the manner in which the Clinical Director, Dr. Gotcher, PhD (ngotcher@cornerstoneok.org or 405-455-6868) handles a complaint, you may submit a formal complaint to:

Attn: Director Office for Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201

This notice was published and becomes effective on signed date below. It will remain in effect for two years from this date.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Cornerstone Representative Signature Date

Financial Responsibility Statement

Patient full name: _____

Patient's DOB: ____/____/_____

Primary Insurance: _____

Policy Holder Name: _____ Date of birth: _____

Member ID Number: _____ Group Number: _____

Phone Number: _____

Secondary Insurance: _____

Policy Holder Name: _____ Date of birth: _____

Member ID Number: _____ Group Number: _____

Phone Number: _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Cornerstone Behavioral Pediatrics, and authorize Cornerstone Behavioral Pediatrics to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

By signing this form I am stating that I understand and agree to the following:
Fees for services were reviewed with me and agreed upon prior to the commencement of services. Payment is due at the time services are rendered unless other arrangements have been made. All returned checks will result in a $25.00 return fee. Failure to meet financial obligations will result in termination of services.

I, _____, (print name) assume all financial responsibility for charges related to all services provided by Cornerstone BH&PT for _____ (print child's name).

_____ _____

Signature of Parent or Legal Guardian Date

Authorization for Release of Information

Patient Name: _____ Date of Birth: ____/____/____

I authorize Cornerstone to release information TO:

1. Name of Provider or Facility:_____
   Address:_____
   Phone number:_____
   Fax number:_____
   Information requested/authorized: ☐ Evaluation ☐ Records ☐ Other: _____

2. Name of Provider or Facility:_____
   Address:_____
   Phone number:_____
   Fax number:_____
   Information requested/authorized: ☐ Evaluation ☐ Records ☐ Other: _____

I authorize Cornerstone to obtain information FROM:

1. Name of Provider or Facility:_____
   Address:_____
   Phone number:_____
   Fax number:_____
   Information requested/authorized: ☐ Evaluation ☐ Records ☐ Other: _____

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Cornerstone Representative Date

Consent for Mental Health Evaluation and/or Treatment

I consent to the evaluation and/or treatment of _____ at Cornerstone Behavioral Health and Pediatric Therapies and authorize the qualified personnel thereof to perform such diagnostic procedures and administer such care and treatments as may be directed by the clinic policy or ordered and/or prescribed by the clinical staff person who is responsible for my child's care. The information herein is in addition to the information contained in the Cornerstone Notice of Privacy Practices.

I acknowledge that I have been fully informed of the evaluation procedures; care and/or treatment of my child, and any risks associated with it have been addressed to my satisfaction. I understand that I may be asked to participate in my child's therapy/ evaluation. I understand that the professionals and staff of Cornerstone Behavioral Health and Pediatric Therapies are required by Oklahoma law to report reasonable suspicions of child maltreatment. I understand that if I or my child is in danger of hurting ourselves or others, this information may be reported in order to obtain appropriate protection. I understand that professionals and staff of Cornerstone will keep records and information regarding my child's treatment confidential, except as authorized by me, as required by law, or as needed to protect persons from harm and to respond to reasonable suspicions that harm has occurred. I understand that Cornerstone professionals and staff may share information among themselves for the purposes of coordinating care, professional consultation and for other purposes necessary to carry out regular clinic operations. I understand that the information shared will be the minimum necessary to carry out these activities. I give permission for the person who brings my child for an evaluation and/or treatment to provide and to receive information concerning him/her.

I understand and agree that Cornerstone does not perform custody evaluations for children or forensic evaluations (to examine and evaluate a patient in anticipation of prosecution or litigation. I agree not to use Cornerstone's evaluation or treatment information to gain advantage in any legal proceedings related to a custodial arrangement. Additionally, I agree that in any such proceedings, I will not ask Cornerstone staff to testify in court, whether in person, or by affidavit. I agree to instruct attorneys not to subpoena Cornerstone staff or to refer in any court filing to anything Cornerstone staff have said or done. Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If Cornerstone professionals are required to testify, Cornerstone professionals are ethically bound not to give their opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, Cornerstone professionals will provide information as needed (if appropriate releases are signed or a court order is provided), but Cornerstone professionals will not make any recommendation about the final decision.

Furthermore, if Cornerstone professionals are required to appear as a witness, the party responsible for Cornerstone professional's participation agrees to reimburse Cornerstone Behavioral Health & Pediatric Therapies at the rate of $750 per hour for time spent traveling, preparing reports, testifying, being in attendance and any other case-related costs.

I understand and agree that the professionals and staff of Cornerstone, when services are billed to a 3rd party insurance provider, will contact and provide information to my insurance carrier in order to obtain payment for evaluation and/or treatment services, and to document the child's evaluation results, treatment plan (if any), and diagnosis (as required by applicable contracts). I understand that payment or co-payment, if applicable, is due at the time of service, unless other arrangements have been made in advance.

The information in this consent has been discussed with me. I have been given the opportunity to ask questions I have regarding this consent. I am legally authorized to consent to the services provided by Cornerstone for the above-named child patient.

_____ _____

Patient Name Patient DOB

_____ _____

Signature of Parent or Guardian Date of Consent

Cornerstone
BEHAVIORAL HEALTH
PEDIATRIC THERAPIES

Patient Attendance Policy

Early notification of your evaluation or feedback appointments' cancellation is vital as it allows us to provide services to other children waiting to be seen. It also allows us a better opportunity to re-schedule your child to another time for testing, and be sure that you have the opportunity to discuss results with the psychologist. Canceled evaluation appointments may be rescheduled if at least 24 hours notice is given by calling our office at 405-455-6868. In order to allow us to meet the needs of our current patients and those on the waitlist to be seen, we have attendance policies that must be followed. A violation of these policies will result in your child being taken off the evaluation schedule.

Evaluation/Testing Appointment Cancellation Policy:

- Call the office at least 24 hours in advance to cancel or reschedule an appointment for an unplanned absence.
- Cancellations under 24 hours are acceptable only due to illness, death in the family, or other significant family emergencies.
- Any missed visit without 24 hour notice will result in a $50.00 charge.

  We try to offer appointment times that are most convenient for your busy schedule. If you need to reschedule your appointment with short notice, please understand that you may need to see another psychologist, accept a less than optimal appointment time, or wait until the next scheduled opening becomes available.

In the following instances, your evaluation appointment will not be rescheduled:

- **Cancellation of 2 evaluation appointments for any reason.**
- **No showing 1 time. No showing is defined as not providing notice of non attendance prior to the scheduled appointment time.**

Drop Off Policy: Cornerstone acknowledges that your time is valuable. After parent interview and completion of rating scales, parents/guardians may leave the premises during their child's testing session if we have an emergency contact number to reach you. If you do not have an emergency contact number, we require that you remain on the premises. If your emergency contact number changes, it is your responsibility to update the information with us. We kindly request that you be available 5-10 minutes PRIOR to the end of your child's testing so that the psychologist may talk with you. If you are unavailable 10 minutes prior to the end of the testing session or arrive late to pick up your child, the psychologist may not be able to address strategies or questions as they have other children waiting to be seen.

**Medicaid clients will not be charged the fee*

ILLNESS

For the safety of other children and our staff, please do not bring your child to their evaluation if your child is ill. When your child is sick, please call the clinic to cancel your appointment as soon as possible. Below are guidelines to assist you in deciding whether your child should attend the appointment. If a child arrives and/or is

brought to Cornerstone Behavioral Health & Pediatric Therapies and is believed to be ill or contagious, the guardian will be notified immediately and will be asked to reschedule.

Children should be kept at home when they meet the following criteria:

- Temperature of 99.9°, or higher, in the past 24 hours.
- Conjunctivitis ("pink eye"), pink/redness of the eye and/or lids, usually with yellow discharge and crusting.
- Bronchitis, COVID-19*, virus/flu with hoarseness, cough, and fever.
- A rash you cannot identify which has not been diagnosed.
- Impetigo: red pimples, which become small vesicles surrounded by a reddened area. When blisters break, the surface is raw and weeping. Look for signs in neck creases, groin, underarms, face, hands, or edge of diaper.
- Diarrhea three or more times within 24 hours (watery or greenish BM's that look different and are more frequent than usual).
- Vomiting within 24 hours (more than usual "spitting up").
- A severe cold with fever, sneezing, and nose drainage.
- An unknown illness without obvious symptoms other than unusual paleness, irritability, tiredness, or lack of interest.
- A contagious disease, including measles, chicken pox, mumps, roseola, strep throat, etc.
- Hair lice (same as public school policy).

While we regret the inconvenience caused by strict adherence to these guidelines, our concern for all the children dictates a very conservative approach when dealing with health matters.

Safe Return After an Illness:

Usually a child can return to the clinic under these circumstances:

- The child has been fever free without fever reducing medication for 24 hours.
- The child has been diagnosed as having a bacterial infection and has been on an antibiotic for 24 hours.
- It has been 24 hours since the last episode of vomiting or diarrhea.
- The nasal discharge is not thick, yellow, or green.
- Eyes are no longer discharging, or the condition has been treated with an antibiotic for 24 hours.
- Ringworm- antibiotic treatment and keep the area covered.
  Other rash has subsided, or a physician has determined that the rash is not contagious.

*__Physician documentation is required.__

Inclement Weather

- In the event of inclement weather, Cornerstone Administration will closely monitor the weather and notify patients about clinic closures via text or telephone.
- During prolonged weather events, daily updates will be sent via text and/or email regarding closure, delayed openings or early closings.
- Occasionally, we may reopen the office if it is determined that streets are clear and safe for travel.
- If you are unable to keep an appointment due to weather conditions, please notify the clinic at Ext.1, as soon as possible.

Acknowledgment- I have read the attendance policy and acknowledge my understanding as well as agree to the terms.

_____

Patient Name

_____ _____

Signature of Parent or Guardian Date