997 Atlantic Blvd Atlantic Beach, FL 32233
(904) 647-1849
jaxbloom.com

Practice Policies and Information

Treatment Fee Structure:

ABA Services:

Initial ABA Assessment: **$750**
$140 per hour for BCBAs
$100 per hour for BCaBAs.
$80 per hour for Registered Behavior Technicians (RBT)
Petit Sprouts: the above listed applicable rates as Petit Sprouts is 1:1 ABA treatment
All ABA clinicians and therapists are certified through the Behavior Analysts Certification Board (BACB)

Feeding Therapy

55 minute Feeding Therapy Consultation (no written report): **$150**
Feeding Therapy Evaluation with written plan of care and nutritional goals**: $500**
55 minute Feeding Intervention**:$145 with a BCBA**
55 minute Feeding Intervention: **$80 with a RBT**

Occupational Therapy:

Initial Evaluation by a licensed Occupational Therapist: **$375**
Treatment provided by a licensed Occupational Therapist: **$125 per hour**
Treatment provided by a licensed Certified Occupational Therapy Assistant (COTA) under the supervision of a licensed OT: **$60 per hour**

Speech Therapy:

Initial Evaluation by a licensed Speech Language Pathologist (SLP): **$375**
Treatment provided by a licensed Speech Language Pathologist**: $80 per half hour**

******The fee structure for all services rendered through Bloom Behavioral Solutions, Inc. is subject to change.***

Cancellations:

Cancellations with less than 24 hours notification: **$75 per appointment** (Please refer to our cancellation policy for more details)

Late Pick-Up Fees: If a patient is picked up more than 5 minutes late of their scheduled session, a $1.00 per minute late will be charged. After 20 minutes has passed since the end of scheduled appointment, and there has been no contact with family or emergency contacts, DCF or the appropriate authorities will be contacted.

Late Drop Off: Patients that are 20 minutes late are considered a cancellation and will be subject to cancellation fees. The appointment will be canceled and the provider may take a different appointment.

Early Pick Up: In the event that you need to pick up your child earlier than their agreed upon pick up time, you must call and notify the clinic as soon as possible. We understand that emergencies or other issues arise from time to time, but interruption of appointment durations affects the schedule for our clinicians and they are not able to fill that appointment time with another patient. Bloom personnel reserve the right to determine if there are habitual patterns of early pick ups. If the pattern is excessive, we reserve the right to modify the patient's schedule.

Payments

All Payments are due at the time services are rendered. Payments include private pay fees, co-payments, cost shares, unmet deductibles, and any other miscellaneous charges**. As a courtesy, Bloom will submit claims on your behalf to your insurance company. In the event that services are not covered, the appropriate responsible party will be invoiced for the services rendered.**

Past due accounts are charged a late fee of **10% of the total bill** per 30 days. Accounts 90 days past due will be sent to collections.

Clients whose accounts are in a past due status and who have not made **prior** arrangements with our office manager for payment may have services put on hold until payment is received. In the event that services are placed on hold due to financial default, the client's prior treatment schedule may no longer be valid. If and when services resume when the account becomes current, a new scheduling contract may be required due to limitations within the company's scheduling and staffing abilities.

In some cases, materials may be purchased for the client. Such purchases may include food, diapers, etc. These items will go on an invoice and must be paid at the time services are rendered.

Clients who are seeking third party reimbursement acknowledge the client's ultimate financial responsibility for services rendered in the event that your insurance company denies payment, or does not remit payment to Bloom.

Appointments & Scheduling

Description of Services:

We are able to provide treatment within the boundaries of your scheduling agreement. **Bloom is not equipped to provide on-call services, emergency treatment, or services off site (e.g. in-home/in-school treatment).** In special circumstances, and advanced scheduling, we may accommodate meetings, PMT, off-site treatment, etc. outside of the agreed upon treatment schedule.

Scheduling Procedures:

There are many variables incorporated with the development of a treatment schedule. Such variables include insurance coverage, treatment authorizations, program needs, permitted providers, and therapist availability. We will do our best to accommodate requested days/times. However, please note that the aforementioned variables may impede certain requests.

Please Note: An assessment does NOT guarantee further provision of services. Services are recommended based upon the clinical recommendation of the provider, medical necessity, and service availability.

Scheduling Agreement:

Once a set schedule is developed for a patient, the client will be provided with a scheduling agreement that states that they understand and will adhere to the treatment schedule. Please refer to the cancellation and attendance policy for fees. The scheduling agreement is NOT a guarantee of services. Due to expected and unexpected variables, this may include, but is not limited to clinician availability, illness, authorizations requirements/restrictions, and time when the clinic is closed due to trainings or extreme weather related emergencies. Throughout the duration of treatment at Bloom, schedules may be modified due to medical necessity as well. Such circumstances include clinical recommendations for the increase or reduction in treatment based upon patient progress.

Arrival Procedures:

If you arrive early to your appointment, you are more than welcome to wait in the lobby. Please note that our therapists typically have appointments back to back. Thus, in most cases we are not able to start the scheduled therapy session in advance if you arrive early. **Please note, repeated late arrivals may lead to changes within the treatment schedule**.

Patients will be issued a PIN to access the lobby area. This will be established at the Intake Meeting. If you feel the PIN granted to you has been compromised, please contact the management staff immediately. Management will change the PIN periodically and you may be notified via text or in person of any changes.

Late Fees:

Please arrive 10 minutes prior to the end of your therapy appointment to discuss the progress of the session. If you arrive more than 5 minutes past the scheduled ending time of your appointment, your account will be subject to a late fee of a $1 per minute late***. All late fee payments are due before your next appointment. If payment is not made by that date, services may not be rendered. In the event that late arrivals are reoccurring, your set schedule may be modified or no longer honored.***

Cancellation and Attendance Policies:

Illness Policy

If a patient is ill, please notify the clinic as soon as possible to reschedule your appointment. Illness for Bloom Behavioral Solutions is defined as vomiting and/or diarrhea, having a fever, eyes or respiratory discharge, open sores that are not able to be covered, and/or having known bacterial infections. In order to return to therapy, the patient must be fever free for 24 hours.

Patients that present with illness symptoms may be sent home at the discretion of management.

In the event that patients miss more than 3 consecutive appointments, are hospitalized, or seeks medical attention from a hospital facility, they must provide a physician's note to return to therapy. A copy of medical records outlining physical restrictions upon return to therapy must also be provided.

At Bloom we take universal medical facility precautions for the protection of our clients and staff.

Cancellations

A cancellation with **less than 24 hours**, may result in a **$75 fee per cancellation**. A cancellation is defined per appointment. For instance, if a patient is scheduled for three different therapies (ABA, OT, Speech), the fee will be $225. We ask that you provide our staff with as much notice as possible for cancellations, so that we may modify the therapist's schedules accordingly.

Attendance Expectations

Each client is expected to **attend 90% of therapy** per their contractual scheduling agreement **per quarter**, as outlined prior to the commencement of continuous care. The scheduling agreement is based upon clinician recommended care, clinician, and client availability, and client agreement. The quarters are based upon the 12-month calendar year beginning in January.

Discharge and Transfer of Service Procedures

All providers at Bloom comply with the discharge and fade out plans outlined by the insurance companies and authorized plans of care. It is common for therapists to refer a client to a different practice to accommodate the specific needs of a patient and/or adhere to company policies. Additionally, failure to adhere to contingency contracts between Bloom Behavioral Solutions, Inc. and the appropriate client parties, transfer and discharge procedures may take place. Please refer to your individual agreements with your therapists for specific discharge criteria.

Bloom Behavioral Solutions, Inc. adheres to all required ethical standards and guidelines from the BACB and the enforceable standards of the APA for all services, including discharge and transfer of service procedures. Bloom Behavioral Solutions, Inc. reserves the right to cease services if the client does not adhere to the company policies outlined in the present document. Bloom Behavioral Solutions, Inc. does not discriminate between race, gender, religious belief, or sexual orientation.

Expectations from Caregivers and Guardians for Clinical and On-Site Treatment:

Caregiver Training & Observation

To ensure the continuity of care it is essential that caregivers participate in the treatment plan of the patient. Caregiver training takes place in the clinic and MUST be scheduled in advance with the supervising BCBA. Observations of treatment are encouraged, but also must be scheduled with advance notice. This is to ensure arrangements can be made to maintain patient privacy and HIPAA compliance.

Caregivers such as parents or legal guardians are expected to attend monthly meetings with therapists and supervisors to review current prognosis and further clinical expectations. Your therapist/supervising clinician may require you to collect data in the home environment to track behavioral progress. This is an integral part of therapy, and necessary for appropriate modifications to treatment plans. Additionally, caregiver training may be a program requirement based upon treatment goals and generalization of skill acquisition.

Contingency Contracts may be required based upon your child's program and amount of necessary caregiver training.

Clinical Materials Responsibility

Caregivers are responsible for all materials necessary to provide for a patient's basic needs and treatment program. This may include, but is not limited to food, additional clothing, reinforcers, communication devices, toileting materials, etc. In the event that necessary materials are not sufficiently provided, Bloom may provide such resources and bill the client for the amount purchased.

All patients MUST provide a change of clithes including undergarments and socks. Bloom provides a toileting bin and a snack bin for all patients. The bins are about the size of a standard shoe box. Thus, all toileting items such as diapers and wipes can NOT exceed what can fit into the bin. Additionally, all consumable items must also fit into a shoe box size bin. We do not have the storage capacity to accommodate bulk items or overflow inventory.

Ethical Guidelines

Although the relationship between a provider and client involves personal interactions and discussions, it is important that a professional relationship is maintained. Each discipline offered by Bloom Behavioral Solutions is subject to ethical standards set forth by the governing body of that disciple. Below are examples of situations that can become ethical concerns and therefore dictate the interaction a provider can have with a client.

- Dual Relationships: Guidelines require that Dual Relationships between provider and client be avoided. The relationship between the provider and the client should be a professional one, with focus on the client and his or her treatment. To prevent dual relationships from forming, the following policies have been developed.

- Social Media (i.e. Facebook, Twitter, Instagram, text messaging, etc.): It is policy that staff is not connected to active providers/active clients through social media websites including, but not limited to, Facebook, Twitter, Instagram, etc. If text messaging is the preferred form of communication for the parents, it is only to discuss scheduling and cancellations. In addition, all email communication should be client-focused.
- Gifts (birthdays, holidays, goodbyes, etc.): In order to prevent potential dual relationships from forming, Bloom Behavioral Solutions has a gift policy in place that prevents staff from accepting gifts of any type from a client. While we very much appreciate this token, it can make the provider-client relationship cloudy and difficult to prevent from turning into a dual relationship.

Any client/patient with concern or complaints can complete the Patient Concern Form or request to speak with the owner or Business Manager.

The following is a list of governing boards and the website to access each discipline's Code of Ethics:

Behavior Analyst Certification Board

- https://www.bacb.com/wp-content/uploads/BACB-Compliance-Code-english_190318.pdf

American Speech-Language Hearing Association (ASHA)

- https://www.asha.org/Code-of-Ethics/

The American Occupation Therapy Association, Inc. (AOTA)

- https://www.aota.org/Practice/Ethics.aspx

CLIENT RIGHTS AND RESPONSIBLITIES

- Clients have the right to be treated with dignity and respect.
- Clients have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
- Clients have the right to have their treatment and other client information kept private.
- Clients have the right to have an easy-to- understand explanation of their condition and treatment.
- Clients have the right to know all about their treatment choices, regardless of cost or coverage.
- Clients have the right to information about providers.
- Clients have the right to know the client clinical guidelines used in providing and/or managing their care.
- Clients have the right to share in the formation of their treatment plan.
- Clients have the right to know about their rights and responsibilities in the treatment process.
- Clients and providers have the right to be treated and work in an environment that is free from any form of sexual harassment.
- Clients have the responsibility to give providers the information they need to deliver the best possible care.
- Clients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Clients have the responsibility to follow their medication plan. They must tell their provider about medication changes, including medications given to them by other providers.
- Clients have the responsibility to treat those giving them care with dignity and respect.
- Clients have the responsibility to keep their appointments. Clients should call their providers as soon as possible if they need to cancel visits.
- Clients have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.
- Clients have the responsibility to follow the plans and instructions for their care. The care is to be agreed upon by the client and provider.
- Clients have the responsibility to know the terms of their insurance policy coverage.
- Clients have the responsibility to pay for services rendered in a timely manner.

Bloom Behavioral Solutions staff are required to abide by the Mandatory Reporting rules as outlined in Section 39.201, Florida Statutes.

"Any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare is a mandatory reporter."

Please contact the following staff for information regarding financial accounts:

Jennifer Vaesa, B.A. --- Office/Business Manager jvaesa@jaxbloom.com

Please contact our Clinical Director for clinical matters:

Samantha Tool, OTD, OTR/L – Practice Manager stool@jaxbloom.com

Shannon Nowell, M.Ed, BCBA – Director of ABA snowell@jaxbloom.com

Genevieve Covington, M.A., BCBA—Founder gcovington@jaxbloom.com

For scheduling matters, please email: scheduling@jaxbloom.com

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Please provide the patient name and DOB below and sign to acknowledge that you have read, understand, and agree to the terms and policies outlined within this document.

By signing below, you agree to the terms outlined within this document. You also agree that failure to adhere to our practice policies may result in termination of services, and any outstanding accounts may be sent to collections.

_____ _____

Patient Name Patient DOB

_____ _____

Client Signature Date

997 Atlantic Blvd Atlantic Beach, FL 32233
(904) 647-1849
www.jaxbloom.com

Pediatric Patient Profile

Contact Information

Patient First Name		**Patient Last Name**	
DOB		**Patient SSN**	
Sex		**Preferred Language**	
Primary Address			
Secondary Address			
Parent/Guardian 1 First Name		**Parent/Guardian 1 Last Name**	
Parent/Guardian 2 First Name		**Parent/Guardian 2 Last Name**	
Parent/Guardian 1 Phone Number		**Parent/Guardian 2 Phone Number**	
Parent/Guardian 1 Email Address			
Parent/Guardian 2 Email Address			

Emergency Contact Information: ***At least one emergency contact person must be listed with contact information.***

First and Last Name	Relationship to patient	Phone Number	Home Address

Insurance Information

Primary:

Insurance Provider		Plan Type	
Group Number		Policy Number	
Policy Holder First Name		Policy Holder Last Name	
Policy Holder SSN		Policy Holder DOB	

Does the Insurance cover ABA services?	◯ Yes	◯ No	◯ Unknown
Does the Insurance cover OT services?	◯ Yes	◯ No	◯ Unknown
Does the Insurance cover SLP services?	◯ Yes	◯ No	◯ Unknown

Secondary:

Insurance Provider		Plan Type	
Group Number		Policy Number	
Policy Holder First Name		Policy Holder Last Name	
Policy Holder SSN		Policy Holder DOB	

Does the Insurance cover ABA services?	◯ Yes	◯ No	◯ Unknown
Does the Insurance cover OT services?	◯ Yes	◯ No	◯ Unknown
Does the Insurance cover SLP services?	◯ Yes	◯ No	◯ Unknown

Physician Information

Referring Physician Name	Practice Name	Office Phone Number

Please list all current Physicians, Specialists, or Therapists

Physician or Clinician	Practice Name	Phone Number

Please list all previous Physicians, Specialists, or Therapists

Physician or Clinician	Practice Name	Phone Number

***** *Please provide any and all necessary diagnostic paperwork, testing, and IEPs from other providers or academic institutions. This paperwork is often necessary for authorization of services from most insurance companies.*

Medical Information

Medical and Psychological Diagnoses

Diagnosis	Date of Diagnosis	Diagnosing Physician	Physician Phone Number

Birth Order of Patient		What if any, medications were taken during pregnancy?			
Length of pregnancy		Breech birth?			
Caesarian?		Convulsions at birth?			
Breathing difficulty at birth?		Other problems at birth?			
Injuries at birth		Birth weight		How many weeks at birth?	
Breast fed? If yes, how long?		Child sat alone at how many months?		Child walked alone at how many months?	
Feeding difficulties?					
Was rate of growth normal?		General development up to the age of 3?			
Swallowing difficulties?		◯ Slow ◯ Average ◯ Rapid			
Did child control body movements?		Is the child Curious?		General Health ◯ Good ◯ Fair ◯ Poor	
Any history of ear infections?		First words at how many months?		Put words together at how many months?	

Any hospitalizations or surgeries?					
Adenoids Removed?		Tonsils removed?		History of ear tubes?	
Does the child have any vision problems? If so, do they wear glasses?		Date of last vision screening		Date of last hearing test	

Any family members with hearing problems?

Relationship: _____ Age: _____

Does Your child exhibit problematic or crisis behaviors? (For example: Aggression, self-injury, property destruction):

- ☐ Yes, mild to moderate behaviors
- ☐ Yes, severe problem behavior that sometimes requires crisis intervention
- ☐ Yes, requires protective equipment
- ☐ Yes, class disruption
- ☐ Yes, other (e.g. PICA, elopement risk
- ☐ My child does not exhibit any crisis behaviors

IF yes, please describe below:

Allergy/ Medical Alert Information

Tree or Nut Allergies	◯ Yes ◯ No	Epi-pen Prescription	◯ Yes ◯ No

Please list all other allergy information below

Allergy	Reaction	Severity on Scale of 1-10	Allergy Medication Prescribed

Please list any and all medical alerts *(e.g., seizure disorders, elopement risk, diabetes, etc.*) and corresponding precursor symptoms/behaviors if applicable:

Medical Alert	Medications or safety equipment/safety plans

Current Medications and Dosages:

Medication	Dosage	Dosing Frequency

Psychosocial Family History:

Please list any family history of developmental delay, neurological disorders, psychological disorders, or other relevant diagnoses

Family Member	Diagnosis	Are they currently taking medications or in treatment for the diagnosis?

Language

Primary language of the patient	
Does the patient use alternative methods of communication (e.g., PECS, device)?	
Primary language of caregivers	
Does the patient live in a bilingual household? If yes what languages	

Please describe your primary concerns below:

Please use the table below to tell us about the patient's current schedule, including school, other therapies, extracurricular activities, occupation, etc. so that we know your availability for therapy.

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8am					
9am					
10am					
11am					
12pm					
1pm					
2pm					
3pm					
4pm					
5pm					
6pm					

Release and Statement to Permit Payment of Private Insurance Benefits to the Provider(s)

I _____, herby authorize Bloom Behavioral Solutions, Inc. and its employees to contact my insurance company that I have listed above to verify benefits for _____. I authorize the release of medical information as necessary to assist in the payment of any third party, or insurance company, and that payments be made directly to Bloom Behavioral Solutions, Inc. for any services rendered to the patient. I authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled. The signature furnished below shall suffice for all insurance forms from this date forward.

_____ _____

Signature of Responsible Party **Date**

Consent for Treatment

I, _____consent to, and authorize the performance of any assessments, evaluations, and intervention procedures, as deemed medically necessary by any clinician to provide initial, and ongoing effective treatment to _____. I understand that to update plans of care, additional testing or assessments may be required at any time during treatment.

_____ _____

Signature of Responsible Party **Date**

Agreement to Pay for Treatment

As a courtesy, Bloom Behavioral Solutions will submit claims on your behalf. However, claims submission is not a guarantee of reimbursement from the insurance company.

I, _____ agree to pay all the charges submitted by this office during the course of treatment for the patient. If the patient has insurance benefits that cover the services rendered, I agree to pay all applicable co-payments, co-insurance and deductibles. I further understand that **I am 100% responsible for all fees at the time services are rendered**, **and that verification of benefits is not a guarantee of payment**. In the event that my health insurance does not cover rendered treatment, I am financially responsible for all services.

I authorize that all the information provided is accurate and true. Should any of the information change, including but not limited to, diagnoses, medication, allergy and medical alerts, insurance benefits, etc. it is my responsibility to provide the updated information to Bloom Behavioral Solutions, Inc.

_____ _____

Signature of Responsible Party **Date**

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(904) 647-1849

Cancellation Policy

A cancellation with **less than 24 hours**, may result in a **$75 fee per cancellation**. A cancellation is defined per appointment. For instance, if a patient is scheduled for three different therapies (ABA, OT, Speech), the fee will be $225. We ask that you provide our staff with as much notice as possible for cancellations, so that we may modify the therapist's schedules accordingly.

Each client is expected to **attend 90% of therapy** per their contractual scheduling agreement **per quarter**, as outlined prior to the commencement of continuous care. The scheduling agreement is based upon clinician recommended care, clinician, and client availability, and client agreement. The quarters are based upon the 12 month calendar year beginning in January.

In the event that you attend less than 90% of therapy appointments, you will be charged $50 per cancellation until the following quarter starts over.

Bloom Behavioral Solutions, Inc. reserves the right to modify a client's schedule due to circumstances of chronic illness, or other variables that may affect a client's attendance, and adherence to the company policy.

We value each of our client's and strive to provide the best care possible. Our cancellation and attendance policies is to protect the integrity of our care, progression within the patient's Plan of Care, and the schedules of our therapeutic staff. If you find that you may not be able to adhere to the patient's scheduling contract due to chronic illness, financial difficulties, or conflicting arrangements, we will do our best to modify the patient's schedules to work with your needs and availability.

By signing below, you understand, and agree to the terms. You also agree to assume all financial responsibility for cancellation fees.

_____
Patient Name

_____
Patient or Guardian Signature

_____
Date

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Pick Up and Consent to Information Form

Please list the following individuals that have your permission to pick up your child as well as Bloom staff to release information regarding your child to such individuals. Bloom is authorized to contact individuals listed in the event of emergency if parents cannot be reached. Photo identification is required by all unknown individuals prior to the release of the child to individuals listed on this form.

Patient: _____

First & Last Name:		**First & Last Name:**	
Relationship to Client:		**Relationship to Client:**	
Phone Number:		**Phone Number:**	
First & Last Name:		**First & Last Name:**	
Relationship to Client:		**Relationship to Client:**	
Phone Number:		**Phone Number:**	
First & Last Name:		**First & Last Name:**	
Relationship to Client:		**Relationship to Client:**	
Phone Number:		**Phone Number:**	

By signing below you confirm that you give all Bloom staff to release _____ to the above listed individuals, as
(Child's Name)

well as discuss pertinent information regarding the child and their treatment.

_____ _____

Parent/Guardian Signature **Date**

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jaxbloom.com

Audiovisual Policy

Bloom Behavioral Solutions utilizes pictures and video recording for multiple purposes. Clinical rationale for the use of pictures and video recording of patients include treatment review, tracking behaviors, progression analysis, and training of staff and caregivers. For the protection of our patients, the entire premises of the clinic location is under 24 hour video surveillance.

Occasionally Bloom utilizes pictures for marketing purposes. Please check the appropriate box and sign below.

☐ **I do NOT consent to my child's picture being used for marketing purposes (e.g. practice website, brochures, monthly newsletter, and other related publications)**

☐ **I do consent to my child's picture being used for marketing purposes (e.g. practice website, brochures, monthly newsletter, and other related publications)**

Patient Name: _____

_____ _____

Parent/Guardian Printed Name Parent/Guardian Signature

_____

Date

997 Atlantic Blvd Atlantic Beach, FL 32233

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www.jaxbloom.com

Records Release Consent Form

1. I, _____ the parent/legal guardian of _____
(parent/legal guardian name) (Patient Name, and DOB)
am completing this form to allow the use and sharing of my child's protected health information.

2. I authorize the clinicians with Bloom Behavioral Solutions, Inc. who are serving my family and child to share information regarding my child's treatment and service provision with the below noted individuals and/or organizations:

List below the individuals and/or organizations with which you authorize the sharing of information. Please be sure to provide contact information and complete address for each individual or organization.

Name		**Organization**	
Address			
Phone Number		**Fax Number**	

Name		**Organization**	
Address			
Phone Number		**Fax Number**	

Name		**Organization**	
Address			
Phone Number		**Fax Number**	

3. The information will be used/disclosed for the following purposes (ex: continuity of care, custody hearing, etc.)

4. I understand and agree that this authorization will be valid during the time my child is receiving treatment through Bloom Behavioral Solutions, Inc. or during the time span noted here: _____

5. I understand that I can revoke or cancel this authorization at any time by sending a letter to **the Management Staff** at Bloom Behavioral Solutions via email (info@jaxbloom.com) or via mail at **997 Atlantic Blvd, Atlantic Beach FL 32233.** If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that information may have been sent or shared before that date.

6. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my child's access to treatment through Bloom Behavioral Solutions, Inc.

7. I understand that I may inspect and have a copy of the health information described in this authorization.

Parent or legal guardian printed name	Parent or legal guardian signature	Date

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and continue the treatment and follow-up among any provider with Bloom Behavioral Solutions, Inc. that may be involved in the direct or indirect treatment of my child.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments clinician certifications

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the users and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, that you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

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Credit/Debit Card Authorization Form

By signing below, you authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount of your current invoice for services rendered and any associated treatment materials. A receipt for each payment will be emailed to you, and the charge will appear on your bank statement as an "ACH Debit." An email with the amount of your current invoice will be provided three business days prior to the charge. Should you choose to use a different card other than the card on file listed below, you must notify us 24 hours in advance.

Please complete the information below:

I, _____ allow Bloom Behavioral Solutions, Inc. to charge my credit card indicated below, for my
(Print Full Name)
current invoice for therapeutic services, co-pays, unmet deductibles, cost shares, etc.

Billing Address_____ Phone: _____

City, State, Zip: _____ Email: _____

Credit Card Information

Card Holder Name: _____ **Card Number:** _____

Expiration Date: _____ **CVV Number:** _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Bloom Behavioral Solutions in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. 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. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that Bloom may at its discretion attempt to process the charge again within 30 days, and agree to an additional $75 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account 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.

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Consent to Receive Text Messages

By signing below, I authorize Bloom Behavioral Solutions to contact me by SMS text message for appointment changes and/or reminders regarding scheduling.

I understand that message/data rates may apply to messages sent by Bloom Behavioral Solutions under my cell phone plan.

I know that I am under no obligation to authorize Bloom Behavioral Solutions to send me text messages. I may opt-out of receiving these communications at any time by calling the front desk at 904-647-1849.

I understand that text messages are not a substitute for professional or medical attention. Providers and staff will not send any personal health information or medical updates via text message.

By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

I consent to receiving communication by text message

Cell phone number(s):_____

I do not consent to any text messaging communication

Patient Name: _____ Patient DOB: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date Signed: _____

Community Therapy Consent Form

Often our patients benefit from breaks outdoors for activities such as wagon rides, sidewalk chalk drawing, gardening, or small field trips to partnering stores within the community shopping center. Stores such as the Dollar Tree, Pet Supermarket, Sierra Grille, and Marco's Pizza are all aware of the nature of our services and are accustomed to our community outings with patients.

Patient Name: _____

I **do** consent to

I do **NOT** consent to

Bloom providers of my child's care team to take my child into a community setting. This may include shops within the shopping center. Such stores include The Pet Supermarket, The Dollar Tree, Sierra Grille, Panera Bread (only for clients 12 and over) and Marco's Pizza. I understand that prior to a community outing, a member of management will be informed of where my child will be going and the expected time of their return. Such information will also be provided on the patient sign-out sheet.

_____ _____

Parent Signature **Date**