THE FLORIDA CENTER
FOR EARLY CHILDHOOD

PAYMENT FEE AGREEMENT

CLIENT'S NAME: _____DOB: _____

The signature on this Payment Fee Agreement indicates that I (we) understand and agree that, regardless of Insurance status, I (we) are responsible for the payment of services for any and all professional services rendered. Failure to heed this agreement may result in suspension of services.

For those clients on INSURANCE, The Florida Center for Early Childhood will bill the insurance company the full fee for services provided. Should the insurance company reimburse the client directly, the client must sign over the check to The Florida Center for Early Childhood along with a copy of the "Explanation of Benefits" (EOB). The client is responsible for the co-payment and deductible set by the insurance company. Co-payments are due at the time of the visit. The client is responsible for notifying the business office of any change in Insurance Companies. If the client is covered under a MANAGED CARE or HMO contract, the client is responsible for obtaining information pertaining to services, co-payments and other terms and conditions of reimbursement.

Based on available funds, a partial or full "Scholarship" may be established for families who are unable to pay the full fee for requested services that are not covered under any other payment source, such as Medicaid, other insurance plans, Gulf Central Early Steps Program, and/or School Board of Sarasota County. Scholarship funds are not provided to cover deductible or co-payments**.** The scholarship is based on household income and the number of persons residing in the home. I (we) are responsible to notify The Florida Center for Early Childhood of any changes in financial status that may increase or decrease the scholarship. The scholarship will be updated at least annually. Proof of income will be necessary to determine the scholarship funding for the family.

For those clients who have Medicaid, insurance, Gulf Central Early Steps and/or School Board of Sarasota County funding, a scholarship application may be provided to a family when the service recommended for the child is not covered. I (we) understand that the client is responsible for notifying the business office of any change in coverage or primary care physician.

I agree to pay all required fees noted on page 2 of this registration packet at the time services are rendered. Failure to pay at the time services are received may result in termination of services, unless specific written arrangements have been made with the billing office.

Payment Fee Agreement continues on next page!

My (our) calculated costs to the family for services are noted below. Please place "N/A" (not applicable) next to any services covered by another funding source.

Program Service	Florida Center Standard Hourly Fee	Caregiver Fees
Early Childhood Education	Varies with attendance	
Initial Evaluation: Speech, Occupational or Physical Therapy	$ 200.00	
Initial Evaluation: Mental Health Counseling	$ 125.00	
Individual Sessions: ST, OT, and PT	$ 60.00/ 30-minutes $120.00/hour	
Individual Sessions: Mental Health	$ 100.00 PER HOUR	

Please INITIAL:

_____I (we) authorize the release of any medical or other information necessary to process insurance, Medicaid or Part C claims.

_____I (we) authorize payment of medical benefits to The Florida Center for Early Childhood
for services provided.

_____I (we) understand that I will be charged a $25.00 fee for all scheduled appointments canceled without at least 24 hours notice.

I (we) certify that the above information is true and correct to the best of our knowledge. The Florida Center for Early Childhood will be notified immediately of any changes in the above information.

_____ _____/_____/_____
Client Name Date of Birth

_____ _____/_____/_____
Client or Parent/Guardian Signature Date

_____ _____/_____/_____
Witness Signature Date

THE FLORIDA CENTER
FOR EARLY CHILDHOOD

Consent for Treatment and Diagnostic Procedures

Client's Name: _____ Date of Birth: _____/_____/_____

I (we) have been informed of the services offered through The Florida Center for Early Childhood (The Florida Center) and it has been explained that I (we) have a choice about the use of service and the other services that may be available for me and/or my family.

I have been given the opportunity to ask questions about my rights and responsibilities in accepting services. I (we) hereby authorize The Florida Center to provide the following services: (Client/Legal Guardian **must initial** before each service authorized)

_____ Early Childhood Education classrooms
_____ Infant Toddler Developmental Specialist (EI Services)
_____ Mental Health Evaluation/Intervention
_____ Fetal Alcohol Spectrum Disorder (FASD) Evaluation/Intervention
_____ Speech/Language Evaluation/Intervention
_____ Occupational Therapy Evaluation/Intervention
_____ Physical Therapy Evaluation/Intervention
_____ Behavioral Support Services

Please Initial:

_____ I (we) understand that I must closely supervise my child(ren) while at The Florida Center including the lobby, parking lot, bathroom, etc.

_____ I (we) understand that I cannot leave The Florida Center premises or my home when my child(ren) are receiving services.

I also understand that as the client or legal guardian of a child, I am expected to take part in decisions about the plan of care for services received. I have primary custody and possess the authority to make decisions for evaluations and/or treatment on behalf of the above mentioned client. **This document is effective for one year from date of signature.**

_____ _____
Client/Legal Guardian Signature Date

_____ _____
Witness Signature Date

THE FLORIDA CENTER
FOR EARLY CHILDHOOD

AUTHORIZATION FOR RELEASE OF INFORMATION

Client/Child Name: _____DOB: _____/_____/_____

Parent/Guardian Names: _____

All pertinent educational, developmental (ST, OT, PT, EI), mental health, medical and other service records and information can be released / received (**circle one or both**) according to this consent. I am aware that this information will be strictly confidential and will be used to facilitate multi-agency planning and to provide appropriate services for my family and/or my child.

The following records/information may not be released: _____

_____

I understand that this authorization will be **in effect for one year** from _____ to _____.
(**Begin Date**) (**Expiration Date**)

I understand that I may revoke this authorization by written request at any time during this period. I am aware that my revocation of this authorization will not be effective if this authorization was obtained as a condition for treatment and to the extent the person(s) and/or organizations(s) identified above have already acted in reliance upon this authorization.

I hereby authorize The Florida Center for Early Childhood to release/receive written and verbal information concerning the participant identified above, except for information related to AIDS (Acquired Immune Deficiency Syndrome) or HIV testing (Human Immunodeficiency Virus) to/from:

Agency/Individual (**Please initial next to each selected option**):

☐ _____ Gulf Central Early Steps
☐ _____ Children's Medical Services (CMS)
Westcoast Access To Children's Health (WATCH)
☐ _____ Sarasota County Health Department
☐ _____ Early Learning Coalition of Sarasota
☐ _____ Child Care Connection
☐ _____ Department of Children and Families (DCF)
☐ _____ Healthy Families
☐ _____ School Board of Sarasota County
☐ _____ All Children's Outpatient Care of Sarasota
☐ _____ Salvation Army
☐ _____ Children First (Head Start/Early Head Start)
☐ _____ Manatee Glens

☐ _____ Healthy Start Coalition/Healthy Start Program
☐ _____ Safe Children's Coalition:
☐ _____ Physician: _____
☐ _____ Hospital: _____
☐ _____ Specialist: _____
☐ _____ Therapist: _____
☐ _____ Parent/ Guardian _____
☐ _____ Other: _____
☐ _____ Other:_____

Information received or shared is to be used for the coordination of services for client health and family self-sufficiency needs.

_____	_____	_____
Authorized Signature	Relationship	Date
_____	_____	_____
Witness Signature	Print Name	Date

THE FLORIDA CENTER
FOR EARLY CHILDHOOD

CONFIDENTIALITY OF CLIENT INFORMATION

I understand that all information regarding clients seen at The Florida Center for Early Childhood is kept confidential. I understand that information may be shared on a need-to-know basis with appropriate staff (e.g., teachers, therapists), consultants and other professionals.

I understand that I may review and take notes from records regarding services provided by The Florida Center for Early Childhood in the presence of my counselor or therapist. I understand that to receive copies of my, or my minor child's records, or to have records released to any other person or agency, I must request this in writing. The Florida Center for Early Childhood will release records under these circumstances unless a determination has been made that the release of records would cause injury to the client served. I understand that I will be notified of any determination that does not allow release of the records.

I understand that I may add a statement to my, or my minor child's record at any time, and that added statements or responses from The Florida Center for Early Childhood personnel will be included in the record with my knowledge.

I understand that employees of The Florida Center for Early Childhood are "mandatory reporters" of child and adult abuse and neglect. This means that if The Florida Center for Early Childhood's employees have any reason to believe any child or adult is being abused or neglected, they are required by Florida Law to report it to the appropriate authorities. Similarly, The Florida Center for Early Childhood employees may disclose as mandated confidential information without my permission if I am at risk of harming myself or someone else.

Because The Florida Center for Early Childhood receives funding from the State of Florida, I also understand that certain information may be provided to the State for purposes of statistical reporting and program evaluation.

I have read and understood the above, and have had the opportunity to ask any questions.

_____ _____/_____/_____
Client Name Date of Birth

_____ _____/_____/_____
Client or Parent/Guardian Signature Date

_
_____ _____/_____/_____
Witness Signature Date

THE FLORIDA CENTER
FOR EARLY CHILDHOOD

Client Name: _____ Date of Birth:_____/_____/_____

Parent/Legal Guardian: _____ Relationship: _____
(Please print clearly)

Consent for the Use and Disclosure of Medical Information

I understand that as part of my or my child's care, The Florida Center originates and maintains health records describing my or my child's health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my or my child's care and treatment
- A means of communication among the professionals who may contribute to my or my child's care
- A document describing the care provided
- A source of information for applying diagnosis information and a means by which a third-party payer can verify that services billed were actually provided
- A tool to assess the quality of services provided to me or my child
- A source of information for public health officials charged with monitoring the health of the regions they serve

I understand and have been provided with a Notice of Privacy Practices. I understand that The Florida Center may use or disclose my or my child's health information for the purposes of carrying out treatment, obtaining payment, and health care operations. I hereby consent to the use and disclosure of my or my child's health information for the purposes as noted in the Notice of Privacy Practices. I understand that I have the right to revoke this consent by notifying the agency in writing at any time. I understand I may contact the Privacy Officer regarding any questions regarding the Notice of Privacy Practices.

I fully understand and ☐ accept ☐ decline the terms of this consent.

_____
Print Name (Please Print Clearly)

_____ _____/_____/_____
Signature Date

THE FLORIDA CENTER
FOR EARLY CHILDHOOD

CLIENT GRIEVANCE PROCEDURE
AFFIDAVIT OF UNDERSTANDING

I understand that the policy of The Florida Center for Early Childhood is to treat all clients and families with respect and provide the highest quality of services possible. I understand that if differences of opinion or disagreements occur, I have the right to have my concerns or complaints heard and resolved in a timely and respectful manner. I understand that I and/or my child will never be penalized or lose services for registering a complaint or discussing concerns about my or my child's services.

I understand that I must first express my concerns to my treating clinician or service worker and attempt to resolve the difference informally with the clinician and his/her supervisor.

I understand that if my concerns cannot be resolved at this level, I may file a grievance in writing to the Program Director and request a meeting with involved staff and the Program Director, and if necessary the Program's Vice President and/or Chief Executive Officer. These meetings will focus on the best interest of the client involved in the grievance.

The decision of the Vice Presidents and/or the Chief Executive Officer will be final.

I understand that I may choose to use an advocate to assist me. If I do not have an advocate, the names of organizations that may be able to advocate for me will be provided.

I have read and understand the above procedure and have had the opportunity to ask questions.

_____ _____/_____/_____
Client Name Date of Birth

_____ _____/_____/_____
Client or Parent/Guardian Signature Date

_____ _____/_____/_____
Witness Signature Date

THE FLORIDA CENTER
FOR EARLY CHILDHOOD

Child Health and Medical Form

Client's Name: _____ Date of Birth: _____

Parent/Legal Guardian #1 Name: _____
Telephone Numbers: Home: _____ Work: _____
Cell: _____

Parent/Legal Guardian #2 Name: _____
Telephone Numbers: Home: _____ Work: _____
Cell: _____

Emergency Contacts (to whom child may be released if legal guardian is unavailable)

Name #1: _____ Relationship: _____
Telephone Numbers: Home: _____ Work: _____
Cell: _____

Name #2: _____ Relationship: _____
Telephone Numbers: Home: _____ Work: _____
Cell: _____

Child's Usual Source of Medical Care (e.g., Physician, Health Care Center)
Name: _____
Address: _____
Telephone Number: _____

Childs Health Insurance:
Name of Insurance Plan: _____ Policy #: _____
Name of Policy Holder: _____
Policy Holder Date of Birth: _____ Policy Holder SS#: _____

Special Conditions, Disabilities, or Medical Information for Emergency Situations (use back page if needed):
_____
_____
Allergies: _____

Parent/Legal Guardian Consent and Agreement for Emergencies

As parent/legal guardian, I give consent to have my child receive first aid by The Florida Center for Early Childhood staff, and, if necessary, be transported to receive emergency care.

I give consent for the emergency contact person listed above to act on my behalf until I am available. I agree to review and update this information whenever a change occurs and at least every 12 months.

I agree to pay and assume all responsibility for all medical and hospital expenses and any services of an emergency nature, and charges for (my) dependent(s).

I acknowledge and agree that The Florida Center is not responsible for any medical and hospital expenses and charges that are incurred in the medical treatment or hospitalization of (my) dependent (s).

_____ _____/_____/_____
Client or Parent/Guardian Signature Date

_____ _____/_____/_____
Witness Signature Date

THE FLORIDA CENTER
FOR EARLY CHILDHOOD

AUTHORIZATION FOR PHOTOGRAPH OR VIDEOTAPING

Client Name: _____ Date of Birth: _____/_____/_____

Please initial Yes OR No

_____ **Yes** I give my permission, as indicated by my signature below, to The Florida Center for Early Childhood and the staff caring for me and/or my child to photograph or videotape the client named above, to appear in photographs, slides or videotapes for the following purposes:

- ✓ May be used as part of an assessment or intervention with a client or a client and parent in any of the programs at The Florida Center.
- ✓ May be used for educational purposes for staff and/or students.
- ✓ May be used to share with child and/or family of child.
- ✓ May be used for public relations activities, including agency brochures, publications or publicity events.

I waive all edit rights and declare that a representative of The Florida Center may determine the best use without further consent from me. I agree that I am receiving no financial compensation for the use of this material, nor will I receive any compensation in the future.

I hereby release The Florida Center from any liability that may arise as a result of the use of this material. This authorization may be revoked at any time with a written request from the client or client's parent/legal guardian.

_____ **No** I do not, as indicated by my signature below, give my permission to The Florida Center to use the client named above in photographs, slides or videotapes for public relations or fundraising activities.

_____ _____/_____/_____
Client or Parent/Guardian Signature Date

_____ _____
Print Name Relationship

_____ _____/_____/_____
Witness Signature Date

THE FLORIDA CENTER
FOR EARLY CHILDHOOD

CLIENT RIGHTS AND RESPONSIBILITIES

At The Florida Center we respect the value and dignity of each child, individual and family we serve. We respect the rights, needs and worth of all persons who come to us for care.

Hours of Operation: Monday - Friday, 7:30 am to 5:30 pm or by appointment.

CLIENT RIGHTS:

The Client and Family Have the Right:

- To receive quality services without discrimination or prejudice.
- To expect privacy and respect while receiving services.
- To be actively involved in the development of your (your child's) plan of care.
- To expect timely and reasonable answers to your questions.
- To know what services are available to help you, including any special needs that we are able to address.
- To receive assistance with special communication needs or language barriers, such as interpreter services.
- To be kept informed about your (your child's) condition, plan of care, risks, benefits and outcomes.
- To be advised of choices for care or treatment.
- To refuse treatment, except when services are ordered by a court of law, and to be informed of the consequences of refusing treatment.
- To be given complete information on the financial costs of services and of payment plans or fee adjustment requests prior to service delivery.
- To receive access to services regardless of your race, sex, creed, sexual orientation, nationality, religion, disability or source of payment.
- To expect respect for your cultural values and spiritual beliefs.
- To be given care that is sensitive to your individual developmental needs.
- To request changes in your treatment or service provider.
- To be given information on how to submit complaints, grievances or appeals during your initial visit.

CLIENT RESPONSIBILITIES

The Client and Family are Responsible:

- To give true and complete information about your (your child's) present and past health, development and behavior.
- To tell your therapist or care provider if you do not understand your (your child's) plan of care and what is expected of you.
- To follow the plan of care you and your therapist agree to.
- To keep scheduled appointments and, if you cannot, cancel appointments with 24 hour notice.
- To be responsible for your actions if you refuse treatment or do not follow the plan of care you and your therapist agree to.
- To pay your bills for services received.
- To obtain information about services, co-payments and other terms and conditions of reimbursement for services if you are in a HMO or other managed health care program.
- To closely supervise my child/children in the lobby, hallways, parking lot, bathroom, etc.
- To remain on the premises of The Florida Center while my child is receiving services.
- To be considerate of the rights of others and to follow the rules.

_____ ____/____/____
Signature of Parent(s)/Legal Guardian *Date*

_____ ____/____/_____
Signature of Witness *Date*