Desoto Family Counseling
& Pediatric Therapy Center

8626 AIRWAYS BLVD.
SOUTHAVEN, MS. | 38671
PHONE | 662.772.5937
FAX | 662.772.5940

WELCOME TO DESOTO FAMILY COUNSELING AND PEDIATRIC THERAPY CENTER

We are glad you have chosen to become one of our new patients. PLEASE complete each section to the best of your ability. We value our patients and want to ensure you are given the best care possible.

[PATIENT INFORMATION]

LAST NAME_____ FIRST NAME _____ MI _____

DATE OF BIRTH _____ | _____ | _____ SOCIAL SECURITY # _____ | _____ | _____

GENDER [MALE] [FEMALE] [PREFER NOT TO SAY] ADDRESS _____

CITY _____ STATE _____ ZIP _____

MARITAL STATUS - [SINGLE] [MARRIED] [WIDOWED] [DIVORCED] [SEPARATED] SPOUSE NAME [IF MARRIED] _____

EMAIL ADDRESS: _____ CELL # _____ | _____ | _____

MAILING ADDRESS [if different]: _____

[FINANCIALLY RESPONSIBLE PARTY - IF OTHER THAN PATIENT]

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH _____ | _____ | _____ SEX [MALE] [FEMALE]

LAST NAME _____ FIRST NAME _____ MI _____

SOCIAL SECURITY # _____ | _____ | _____ PHONE # _____ | _____ | _____

[INSURANCE INFORMATION]

PRIMARY _____ SECONDARY [IF APPLICABLE] _____

PRIMARY ID _____ GROUP #_____ SECONDARY ID _____GROUP # _____

[SUBSCRIBER INFORMATION - IF OTHER THAN PATIENT]

LAST NAME _____ FIRST NAME _____ MI _____

DATE OF BIRTH _____ | _____ | _____ SOCIAL SECURITY # _____ | _____ | _____ SEX [MALE] [FEMALE]

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____ CELL # _____ | _____ | _____

[EMERGENCY CONTACT INFORMATION]

NAME _____ RELATIONSHIP TO PATIENT _____

DATE OF BIRTH _____ | _____ | _____ PHONE # _____ | _____ | _____

By signing below, I am confirming that all the information I have provided is true to the best of my knowledge.

_____ _____

PATIENT OR PARENT/LEGAL GUARDIAN SIGNATURE DATE

[AUTHORIZATION TO RELEASE MEDICAL INFORMATION/ PAYMENT OF INSURANCE BENEFITS]

I hereby authorize Desoto Family Counseling and Pediatric Therapy Center, PLLC, along with my attending physician, permission to disclose any information from my personal medical records to insurance companies and/or outpatient benefit programs pertaining to my treatment as needed when processing insurance claims. If needed for treatment, I authorize Desoto Family Counseling, PLLC to release information pertaining to any medical screenings (drug/genetic/pregnancy) to third party processors. Furthermore, I assign payment directly to Desoto Family Counseling, PLLC wherein specified and otherwise payable to me but not to exceed any charges rendered by Desoto Family Counseling, PLLC for receiving mental health and/or medical treatment. I understand that I am personally responsible for any charges that are not covered by this authorization.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

[FINANCIAL GUIDELINES]

Please be prepared to pay your copay/co-insurance/self-pay rate /or towards your deductible at your scheduled appointment time. We require payment to be given AT the time of service. Our facility accepts all major credit cards, cash, and MOST HSA/FSA cards. If for some reason your HSA/FSA card does not work/declines your payment - we can print the patient an itemized receipt that can be sent to your HSA/FSA company for reimbursement. Copayments and deductibles are due at the time of service. Please note that any insurance estimates or cost quotes provided are approximations and do not guarantee final coverage or payment by your insurance company. Final charges are subject to your plan's rules, limitations, and actual claim processing. You will be responsible for anything your insurance company does not cover. If you have read our financial policies in completion and agree to comply, please sign and date below.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

[PATIENT COMMUNICATION]

Our office staff is available by phone every Monday through Thursday during business hours [8:00 am to 5:30 pm] [Lunch Break is 12:15 pm to 12:45 pm]. Any scheduling, billing, insurance, or medication inquiries can be made by telephone or in the office. If you need to leave a message for your physician or therapist directly, the front staff will document the information from the caller and give the message to your specified provider. We ask that you give your providers 24-48 hours to follow up with you directly. If the message is regarding a prescription refill, we also ask that you allow 24-48 business hours for your refill to be called in. There is always a possibility there may be some delay time regarding your refill requests due to the physician's necessity to review the patient's chart thoroughly and determine course of action needed. If for some reason you call our office and your call goes unanswered, we ask that you leave a voicemail and allow our staff to call you back as soon as possible.

[COMMUNICATION RESPONSE TIME]

DFCPTC is an outpatient, non-emergent facility and is set up to accommodate individuals who are reasonably safe and resourceful. Unfortunately, our providers do not have a direct line, nor are they always available. If at any time this does not feel like sufficient support, please inform your provider, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Providers will return emails, or texts sent through the Tebra portal within 24-48 business hours. However, our office does not return any form of outside of our regular hours. Regular emails sent outside of the Tebra portal are not protective of your personal information and is not HIPAA compliant. If you are having a mental health emergency and need immediate assistance, please follow one or more of the instructions below.

- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911.
- Go to the emergency room of your choice.

If you have read the terms regarding communication at Desoto Family Counseling, PLLC and are in agreeance to follow them as a patient at our facility, please sign below.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

[APPOINTMENT POLICY]

Our office policy requires ALL appointments needing to be <u>cancelled</u> and/or <u>rescheduled</u> by 1:00 PM the day PRIOR to your appointment. We have this policy set in place so that our providers are given the opportunity to fill in any cancellations that may arise. If a patient cancels and/or reschedules an appointment LATER THAN 1:00 PM the day PRIOR to their appointment – that will be considered a LATE CANCELLATION. If a patient fails to cancel an appointment <u>at all</u> – this will be considered a <u>NO SHOW</u>. We also have a grace-period in which a patient may arrive at the appointment and still be seen. The grace period is as follows:

- Counseling, Occupational, and Physical Therapy has a 20-minute grace period.
- Medication Management has a 10-minute grace period.

- Speech Therapy is based on your scheduled appointment time. Please see your provider for additional information.

If a patient arrives after the grace period, the patient will not be seen by the provider. If a patient consistently arrives to their appointments late but within the grace period, their provider will address this issue with them. Our policy is that if a client accumulates 2 consecutive late cancellations/no shows or 4 total late cancellations/no shows in a 12-month period beginning at the initial appointment, the provider then has the right to refer the patient to another mental health facility and terminate services within Desoto Family Counseling and Pediatric Therapy Center. If a patient ever wants to dispute that an appointment was cancelled within the time stated by our policy, we ask that you address the matter with your provider and in turn the solution can be passed on to our front staff.
If you have read, and agree to, all the terms regarding our appointment cancellation policy please sign below.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

[IMPORTANCE OF INSURANCE TRANSPARENCY]
At Desoto Family Counseling and Pediatric Therapy Center, we strive to provide you with the best care that you, your family, or your child may need. It's imperative that you disclose all insurances that you or your child holds in order to help us give you the best care that we can. The type of insurance that you have dictates which providers are available to you or your child, since not all of our providers are able to take all forms of insurance. When a client fails to tell us about all insurances that they have, the following unfortunate things could occur: insurance billing could be disrupted, services could be paused due to billing being disrupted, the client could have to change providers in the midst of services, etc. If the billing department receives a denial and/or requests a clarification of benefits, services may be paused until clarification has been received or the denied claim has been paid. If a client is unreachable in the event of insurance billing denials, they may be held responsible for the payments.

PLEASE INITIAL:

_____ I understand the importance of disclosing ALL insurance information and agree to disclose all insurance information.

_____ I understand that services could be disrupted due to insurance billing difficulties related to primary/secondary insurance confusion.

[TECHNOLOGY GUIDELINES]

Desoto Family Counseling values the privacy and confidentiality of each patient utilizing services through our facility. There are a few guidelines regarding technology that is available for our patients to utilize throughout their time here at DFCPTC.

- If you choose to receive an appointment reminder via text message – you will receive the reminder 36 hours prior to your scheduled appointment time. Upon arrival of the text reminder – it is the PATIENT'S responsibility to respond [yes] or [no] by 1:00 PM the day prior to your appointment (as previously stated regarding appointment rescheduling).
- Please be aware that although Desoto Family Counseling operates through a secure, HIPAA compliant browser, if you and your provider communicate via email, most common browsers such as Gmail or Yahoo are NOT secure browsers
- Desoto Family Counseling is not under any circumstance authorized to send medical records via email to an unsecured browser
- None of our providers can give any of their personal cell phone numbers to patients at any time. If you are experiencing an emergency – we urge you to call your local acute care facility OR call 911.
- Our staff desires to uphold the most professional and secure environment possible. Unfortunately, we cannot accept any requests from patients via Facebook, Snapchat, Instagram, etc. We ask that no contact via social media be made to any of your providers here at Desoto Family Counseling and Pediatric Therapy Center due to conflict of interest.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

[DECISION TO TERMINATE]
At Desoto Family Counseling and Pediatric Therapy Center, we strive to provide you with the best care that you, your family, or your child may need. However, the therapist oversees the provider/client relationship and may deem it appropriate to terminate services. The following examples of termination reasoning include, but not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflict of interest, failure to participate in therapy services, or that the client would benefit from another therapist. The therapist will discuss the decision to terminate with the client or will send a letter notifying of the decision to terminate along with referral options. The client or client's representative also has the right to terminate services during the therapy process.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

[ACKNOWLEDGEMENT OF PRIVACY PRACTICES]

I, _____ , the client or client's guardian, have been presented with a copy of Desoto Family Counseling and Pediatric Therapy Center's Patient Notification of Privacy Practices, detailing how my or my child's information may be used and disclosed as permitted under federal and state law, and I understand the contents of the notification. By law, Desoto Family Counseling and Pediatric Therapy Center is required to obtain your signature indicating you have received this document. Your signature does not surrender any rights or confidentiality protected by HIPAA.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

[INTERNAL USE ONLY]
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

PRESENTED ON [DATE & TIME] _____

BY [NAME & TITLE] _____

[CLIENTS WITH DIVORCED PARENTS/GUARDIANS]
Desoto Family Counseling and Pediatric Therapy Center requires that all of the most current signed legal custody paperwork be presented at the time of the appointment, so our staff can keep an updated record of the patient's current custody agreement. Any services not covered by insurance should be paid for by whichever party is in financial obligation of the child. If the parent that is not financially responsible for the patient is the one bringing the child to the appointments, it is your responsibility to collect required payment from the responsible party. The responsible party will need to sign a form stating they are aware of their responsibility to provide all payments that are not covered by the child's insurance. We require payment at the time of services; however, we will try our best to accommodate your situation if an unforeseen circumstance were to arise.

If you understand and agree to follow our policy regarding the financially responsible within divorced parents/guardians, please sign below.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____
[DESOTO FAMILY COUNSELING AND PEDIATRIC THERAPY CENTER FEE SCHEDULE]

The following is Desoto Family Counseling and Pediatric Therapy Center's self-pay fee schedule and what will be billed to your insurance, if our office is filing claims to your insurance company. This is not what the patient will owe at the time of service. All rates are subject to change and are updated periodically. Please let the front staff know if you have any questions regarding our fees.

MEDICATION MANAGEMENT [INITIAL]	$175 [PLUS DRUG SCREEN FEE FOR ADULT]
MEDICATIAN MANAGEMENT [FOLLOW-UP]	$85 - $130 [BASED ON TIME SPENT WITH PROVIDER]
THERAPY [INITIAL]	$200
THERAPY [FOLLOW-UP]	$190
THERAPY [FAMILY WITH PATIENT]	$150
THERAPY [FAMILY WITHOUT PATIENT]	$130
NO SHOW/LATE CANCELLATION FEE	$60
MEDICAL RECORDS	$25 [1 TO 25 SHEETS]
ADDITIONAL SHEETS [RE: MEDICAL RECORDS]	$1 [EVERY SHEET AFTER]
TREATMENT SUMMARY	$250 [STARTING AT]
BASIC LETTER FEE / DISABILITY PAPERWORK	$25
DRUG SCREEN [NOT COVERED BY INSURANCE]	$25
PREGNANCY TEST [WOMAN OF CHILDBEARING AGE ONLY]	$8
THERAPIST/LAWYER CONSULTATION [COURT RELATED]	$1,000
COURTROOM TESTIMONY – HALF DAY	$3,500
COURTROON TESTIMONY – FULL DAY	$5,000

OT/PT/SLP EVALUATIONS	$100 - $395
OT/PT/SLP TREATMENTS	$65 - $260

By signing below, I understand Desoto Family Counseling and Pediatric Therapy Center, PLLC. fee schedule and hereby agree to the terms of the office billing policy. I understand that I am responsible for any charges incurred at the time of service, this includes but is not limited to any copay, deductible, co-insurance, and/or lab fees due. I also understand that it is my responsibility to know my insurance benefits and that any price disclosed to me by Desoto Family Counseling and Pediatric Therapy Center, PLLC is a quote and not a guarantee of how my insurance will process my claim.

_____ _____

Patient or Legal Guardian signature *Today's date*

[MEDICARE PATIENT'S ONLY – STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PHYSICIAN]
I certify that the information given by me in applying for payments under the Title XVII of the Social Security Administration or its intermediaries or carriers consists of the accurate information needed for Medicare claims. I request that all authorized benefits payments be made on my behalf. I assign the benefits payments for physician services to the physician or organization furnishing the services along with the authorization to submit any claims to Medicare for payment. By signing below, I am agreeing to these terms set by Desoto Family Counseling, PLLC regarding the insured's Medicare.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

[ETHICS, CLIENT WELFARE, AND SAFETY]
All counseling sessions will be rendered in a professional manner consistent with the ethical standards of the American Counseling Association and/or the National Association of Social Workers. If at any time you feel that the provider is not performing in an ethical or professional manner, we ask that you please let staff know. If we are unable to resolve your concern, DFCPTC staff will provide you with information to contact the professional licensing board that governs counselors. Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, with your consistent participation, our office will work to achieve the best possible results for you or your child. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility, nonetheless.
It is DFCPTC policy that the parent or guardian of any client who is age 12 or younger may not, for any reason, leave the premises while the client is being seen for a session. Additionally, no child under 12 may be left unattended in any area of DFCPTC. For the safety of all our clients, their accompanying family members, and children, our office maintains a zero-tolerance weapons policy. No weapon of any kind is permitted on the premises, including guns, explosives, ammunition, knives, swords, razor blades, pepper spray, garrotes, or anything that could be harmful to yourself or others. DFCPTC reserves the right to contact law enforcement officials and/or terminate treatment with any client who violates our office weapons policy.
If you have read and agree to follow all terms and guidelines referring to client welfare here at Desoto Family Counseling and Pediatric Therapy Center, please sign below.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

[ACKNOWLEDGEMENT OF TELEMENTAL HEALTH POLICY]

I, _____ , the client or the client's guardian, have been presented with a copy of Desoto Family Counseling and Pediatric Therapy Center's Patient Notification of TeleMental Health Policies, detailing the procedures and limitations of TeleMental Health, and I understand the contents of the notification. I have also been given a copy of the Communication Response Time policy, and I understand the contents.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

[CONFIDENTIALITY AND RECORDS]
The providers will always keep everything you say to them completely confidential, with the following exceptions: (1) you direct them to tell someone else and you sign a "Release of Information" form; (2) They determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) They are ordered by a judge to disclose information. In the latter case, their license does provide your provider with the ability to uphold what is legally termed "privileged

communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. The provider cannot guarantee that the appeal will be sustained, but our office will do everything in our power to keep what you say confidential. Please note that in couple's counseling, the provider does not agree to keep secrets. Information revealed in any context may be discussed with either partner.

If you have read and agree to follow all terms and guidelines referring to confidentiality and records here at Desoto Family Counseling and Pediatric Therapy Center, please sign below.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

[DUTY TO UPDATE INSURANCE INFORMATION]
It is the patient's responsibility to communicate to DFCPTC staff if their insurance provider has changed. The patient must call DFCPTC and provide the needed information as well as bring in the new insurance card to be scanned in on the next visit. Any charges that may occur due to failure to update DFCPTC, are the responsibility of the patient.
PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

[AUTHORIZATION TO RELEASE LIMITED INFORMATION]
Desoto Family Counseling and Pediatric Therapy Center offers an automated call/text service that will contact you two business days ahead of time to remind you of your appointment. The automated call will give the message to anyone who answers or leave a voicemail if reached. The automated text will include the provider's name, appointment date and time, and the client's name. Please take care to protect your phone from anyone you do not want to have this information.
Please note that Desoto Family Counseling and Pediatric Therapy Center cannot guarantee you will get a reminder call/text in the event we have difficulty reaching you on the number designated below. Also, appointment reminder call/text are provided as a courtesy, and we ask that you keep up with your appointment times in the event we are unable to call/text.

Please choose one of the following options:

_____ No, I do not want Desoto Family Counseling and Pediatric Therapy Center to make reminder calls for my appointment times.

_____ Yes, I do want Desoto Family Counseling and Pediatric Therapy Center to contact me only via phone call/voicemail at # _____

_____ Yes, I do want Desoto Family Counseling and Pediatric Therapy Center to contact me only via text messaging at # _____

[RELEASE OF INFORMATION FOR FAMILY AND/OR FRIENDS OF THE CLIENT]

If there is anyone, other than the client, that may call and check limited information on the account (example: check appointment times, pick up a prescription/samples, pay a bill, transport a minor, etc..) please list these names below (including parents/legal guardians if patient is under 18) and specify what information they may access. No other information, other than what you list, will be released.

Note: This is not a full medical records access request. That will still require a separate release of information to be signed. If no one other than the patient, please state "NONE".

Name	Relationship
Phone Number	What can be released?
Name	Relationship
Phone Number	What can be released?
Name	Relationship

Phone Number	What can be released?
Name	Relationship
Phone Number	What can be released?

You have the right to revoke this authorization, in writing, at any time. However, your revocation will not be effective to the extent that we have acted in reliance on the authorization.

PATIENT OR PARENT/GUARDIAN SIGNATURE _____DATE_____

WITNESS SIGNATURE _____ DATE _____

WAIVER AND RELEASE OF LIABILITY

IN CONSIDERATION OF the risk of injury that exists while participating in GYM ACTIVITY; and

IN CONSIDERATION OF my OR MY CHILD'S desire to participate in said Activity and being given the right to participate in same;

I HEREBY, for myself, my heirs, executors, administrators, assigns, or personal representatives (hereinafter collectively, "Releasor," "I" or "Me", which terms shall also include Releasor's parents or guardian if Releasor is under 18 years of age), knowingly and voluntarily enter into this WAIVER AND RELEASE OF LIABILITY and hereby waive any and all rights, claims or causes of action of any kind arising out of my participation in the Activity; and

I HEREBY release and forever discharge DESOTO FAMILY COUNSELING AND PEDIATRIC THERAPY CENTER, PLLC, located at, 8626 AIRWAYS BOULEVARD, SOUTHAVEN, MISSISSIPPI, 38671, their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns (collectively "Releasees"), from any physical or psychological injury that I may suffer as a direct result of my participation in the aforementioned Activity.

I AM VOLUNTARILY PARTICIPATING IN THE AFORMENTIONED ACTIVITY AND I AM PARTICIPATING IN THE ACTIVITY ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH PARTICIPATING IN THE ACTIVITY, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO: PHYSICAL OR PSYCHOLOGICAL INJURY, PAIN, SUFFERING, ILLNESS, DIFIGUREMENT, TEMPORARY OR PERMANENT DISABILITY (INCLUDING PARALYSIS), ECONOMIC OR EMOTIONAL LOSS, AND DEATH. I UNDERSTANT THAT THESE INJURIES OR OUTCOMES MAY ARISE FROM MY OWN OR OTHERS' NEGLIGENCE, CONDITIONS RELATED TO TRAVEL TO AND FROOM THE ACTIVITY, OR FROM CONDITIONS AT THE ACTIVITY LOCATIONS(S). NOTETHELESS, I ASSUME ALL RELATED RISKS, BOTH KNOWN AND UNKNOWN TO ME, OF MY PARTICIPATION IN THIS ACTIVITY.

I FURTHER AGREE to indemnify, defend and hold harmless the Releasees against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs.

I FURTHER ACKNOWLEDGE that Releasees are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of Releasees. In the event that I should require medical care of treatment, I authorize _____ to provide all emergency medical care deemed necessary, including but not limited to, first aid, CPR, the use of AEDs, emergency medical transport, and sharing of medical information with medical personnel. I further agree to assume all costs involved and agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

I FURTHER ACKNOWLEDGE that this Activity may involve a test of a person's physical and mental limits and may carry with it the potential for death, serious injury, and property loss. I agree not to participate in the Activity unless I am medically able and properly trained, and I agree to abide by the decision of DESOTO FAMILY COUNSELING AND PEDIATRIC THERAPY CENTER, PLLC official or agent, regarding my approval to participate in the Activity.

I HEREBY ACKNOWELEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE DESOTO FAMILY COUNSELING AND PEDIATRIC THERAPY CENTER, PLLC AND ALL OF ITS AFFILIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESNETIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST DESOTO FAMILY COUNSELING AND PEDIATRIC THERAPY CENTER, PLLC FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases for ordinary negligence, this release is also for such negligence on the part of DESOTO FAMILY COUNSELING AND PEDIATRIC THERAPY CENTER, PLLC, its agents, and employees.

I agree that the Release shall be governed for all purposes by Mississippi law, without regard to any conflict of law principles. This Release supersedes any and all previous oral or written promises or other agreements.

In the event that any damage to equipment or facilities occurs as a result of my or my family's or my agent's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any such actions of neglect or recklessness.

THIS WAIVER AND RELEASE OF LIABILITY SHALL REMAIN IN EFFECT FOR THE DURATION OF MY PARTICIPATION IN THE ACTIVITY, DURING THIS INITIAL AND ALL SUBSEQUENT EVENTS OF PARTICIPATION.

_____
Participant Printed Name

_____
Participant Legal Parent/Guardian Printed Name

_____
Participant Legal Parent/Guardian Signature and Date

OUTDOOR ADVENTURE/PLAY THERAPY
Participant's Release and Waiver of Liability

In consideration of the services of Desoto Family Counseling and Pediatric Therapy Center, PLLC, their agents, trustees, officers, volunteers, participants, employees, and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as "DFCPTC"), I hereby agree to release and discharge DFCPTC, on behalf of myself, my children, my parents, my heirs, assigns, personal representative, and estate as follows:

1. I acknowledge that Outdoor adventure/Play Therapy based recreational activities such as, but are not limited to: canoeing, kayaking, rock climbing, backpacking, caving, ropes courses, mountain biking, hiking, and horse riding (Equine Therapy) entails known and unanticipated risks which could result in physical or emotional injury, paralysis, death, or damage to myself, to property, or to third parties. I understand that such risk simply cannot be eliminated without jeopardizing the essential qualities of the activity.
   The risks include but are not limited to slips and falls while walking in rugged, hazardous terrain; severe weather and environmental conditions; hypothermia; accidental drowning; sprains, strains, joint dislocations, and broken bones; falling from high places; the negligence of other participants; and exposure to potentially harmful wildlife, insects, and plant life.

"I hereby take full responsibility for these risks and understand that other risks may also exist. I take full responsibility for those risks."

2. "I understand that my negligence may result in injury to another person or equipment. I take full responsibility and hold harmless DFCPTC from any claims, demands, or causes of action which are associated with my negligence."
3. "I expressly agree and promise to accept and assume all of the risks existing in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks."
4. "I hereby voluntarily release, forever discharge, and agree to indemnify, defend and hold harmless DFCPTC from any and all claims, demands, or causes of action, which are in any way connected with my participation in this activity or my use of DFCPTC's equipment or facilities."
5. Should DFCPTC or anyone acting on their behalf be required to incur attorney's fees and cost to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.
6. I have read and fully understand the trip description and registration form, medical contact form, and any other materials provided by DFCPTC regarding the trip. I have had the opportunity to ask any questions that I may have about the trip and related activities and the responsibilities and risk involved. All of my questions have been fully answered.
7. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else I agree to bear the cost of such injury or damage myself. I further certify that I have no medical or physical conditions, which could interfere with my safety in this activity, or else I am willing to assume, and bear the cost of, all risks that may be created, directly or indirectly, by such condition.
8. In the event that I file a lawsuit against DFCPTC, I agree to do so solely in the commonwealth of Mississippi, and I further agree that the substantive law of that commonwealth shall apply in that action without regard to the conflict of law rules of that commonwealth.

By signing this document, I acknowledge that if anyone is hurt or property is damaged during my participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against DFCPTC on the basis of any claim from which I have released them herein.

I hereby grant to DFCPTC all rights necessary to enable SC to use, reproduce, assign, and/or distribute, in all forms and in any media, my image and/or photograph or video, and any such other items related to my use of the Outdoor Learning Center for promotion and/or education purposes.

I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.

Participate Signature: _____ Printed Name: _____ Date: _____

PARENTS or GUARDIAN'S ADDITIONAL INDEMNIFICATION (Must be completed for participants under the age of 18)

In consideration of _____(Print minor's name) ("Minor") being permitted by DFCPTC to participate in its activities and to use its equipment and offices, I further agree to indemnify, defend and hold harmless DFCPTC from any and all claims which are brought by, or on behalf of Minor, and which are in any way connected with such use or participation by Minor.

Parent/Guardian Signature: _____ Printed Name: _____ Date: _____

PATIENT-PROVIDER SCREENING POLICY AGREEMENT

Prescribing of controlled medication, as defined by the DEA, is at the discretion of providers acting within the limits of their licensure and DEA classification, acting in the best interest of a patient's medical condition, and balancing the potential of short- and long-term risks of such prescribing to patients and community. Such prescription is performed within the limits of the law, oversight boards, and this policy. Prescribing providers and patients receiving controlled medications for defined prolonged periods of time will enter into a written binding agreement of understanding outlining conditions for prescription, risks, monitoring of utilization, and consequences of lack of compliance as stated in this agreement. This agreement directs that controlled medications will not be refilled by telephone, on the weekends, or by an on-call provider. Lost or stolen controlled medications or prescriptions from their medical provider or another provider will NOT be replaced. This agreement states that the patient will:

1. Be seen regularly, as scheduled, for medication management and refills. Failure to keep these appointments may result in the discontinuation of controlled medications.
2. NOT sell or share medications
3. NOT use other controlled or illegal substances*** while taking prescribed controlled medications.
4. Keep all appointments related to clinical issues necessitating controlled medication use, including appointments with specialists or therapists as agreed upon.
5. NOT engage in abusive or disrespectful behavior toward the provider or office staff members.
6. Provide random urine screens for drug monitoring tests, pregnancy tests (when applicable) and pill counts as requested. Failure to oblige may result in the discontinuation of the prescribing of controlled medications.
    a. The patient will be wholly responsible for the cost of the drug and/or pregnancy test. The screenings are performed in house and will not be billed to insurance. The cost for the drug screen is $25 and the pregnancy test is $8.
7. Notify the provider which pharmacy the prescription is to be filled.

Failure to comply with the terms of the Patient-Provider Screening Policy Agreement will be addressed with the patient and documented in their chart. The provider may use their discretion in determining the consequences of agreement in noncompliance. This determination may include, but not limited to, tapering and/or discontinuing the medications and/or terminating the relationship.

I, _____, have read and understand that my child, _____, or myself will be subject to random urine screens and pill counts at the providers discretion. I also understand that I must follow the controlled substance policy and all treatment recommendations to continue services at this clinic. I understand that I am responsible for the $25 payment of the drug screen fee and/or $8 pregnancy test fee before my appointment and that my insurance company will not be billed. I understand that if my child or myself is unwilling to follow this policy, I will not be seen by my provider and will be referred out of this clinic.

_____

Patient or Legal Guardian signature Today's Date

_____

DFCPTC Staff signature Today's Date