25420 Kuykendahl Rd. Ste 300 Tomball TX 77375
832-356-5152

New Client Information

Client Information:

Name: _____ Date of Birth: _____
Last First Middle
Gender: _____ Diagnosis:_____

Therapy Setting: ___ Clinic ___ Center

Treating Address:_____

Therapy Availability:_____
(please include days/times available for speech services Ex: Monday through Thursday after 1pm)

Parent Information: **Bilingual:**

Parent/Guardian Name:_____ Cell Phone:_____
Home Address: _____
Email**:_____

Secondary Contact:_____Relationship:_____ Phone #: _____

Secondary Contact Email: _____

Insurance Information:

Insurance Name:_____ Insurance ID:_____

Employer:_____ Group #:_____

Policy Holder Name:_____ Policy Holder DOB: _____

Medicaid:

Name on ID Card:_____ Plan:_____ Member ID:_____

Physician Information:

Physician Name:_____ Phone #: (___) _____
Physician Address: _____ Fax #: (___) _____
Last day patient was seen by PCP:_____
Do you have speech referral for your child: Yes No
Child has completed a hearing screen within the last year: Yes No

*Disclaimer: Verification of benefits is a courtesy service provided by Speak Speech Therapy. This quote of benefits and/or authorization does not guarantee payment or how benefits will be applied. Payment of benefits is subject to all terms, conditions, visit limitations and exclusions of the member's contract at the time services are rendered. Services rendered by other providers may affect visit limits and costs.

We must have a credit card on file before we schedule for the Initial Evaluation.

The parent/caregiver is ultimately responsible for independently verifying and tracking benefits for services by Speak Speech Therapy.

Our treating therapist are Speech Language Pathologist-Assistants that are licensed to treat and are supervised by a Speech Language Pathologist.

Thank you for choosing Speak Speech Therapy as your provider.

Parent/Guardian Signature:_____ **Date:**_____

Parent Intake Language Questionnaire

Speak Speech Therapy

25420 Kuykendahl RD Ste F-300/C-400 Tomball, TX 77375
Info@SpeakSpeechTherapy.com
www.SpeakSpeechTherapy.com

Name: _____ DOB: _____ Date: _____
Parent/Caregiver: _____ Phone/Email:
_____

1) Primary Concern

What are your main concerns about your child's communication?

When did you first notice this? _____ Has anyone else expressed concerns?

Yes No

Please explain;

_____
_____

2) Expressive Language (How your child communicates)

How does your child communicate wants/needs? (check all)

points/pulls adult/hand leads gestures vocal sounds single words 2–3 word phrases sentences
repeating phrases/scripts AAC/pictures/device other:
_____

Does your child combine words (ex: "want juice")? Yes Sometimes Not yet

About how many words does your child use consistently?

<20 20–50 50–100 100+ Not sure

Does your child ask questions? Yes Sometimes Not yet What Where Who Why

3) Receptive Language (Understanding)

Responds to name: Yes Sometimes Not yet

Follows 1-step directions ("come here"): Yes Sometimes Not yet

Follows 2-step directions ("get it and bring it"): Yes Sometimes Not yet

Understands WH-questions: What Where Who Not yet

4) Speech Clarity & Frustration

Caregivers understand child: Most Some Rarely

Unfamiliar people understand child: Most Some Rarely

Does your child get frustrated when communicating? Yes Sometimes No
If yes, what happens?
_____

5) Social Communication & Play

Your child: shows/points to share brings items to you enjoys back-and-forth play plays with peers

Pretend play (feeding doll, cooking, etc.): Yes Sometimes Not yet

Favorite activities/toys/topics:
_____

6) Background (check all that apply)

Hearing screening/test: Passed Concerns Not yet Not sure

Ear infections/tubes: Yes No

Languages spoken at home:
_____

Daycare/School: Yes No If yes, where?
_____

Any diagnoses/medical/developmental concerns? Yes No
If yes:
_____
_____

7) Words/Phrases We May Hear (examples)

List 5–10 words/phrases your child says often (or repeats):

8) Parent Priorities (choose up to 3)

use more words/phrases follow directions answer questions improve speech clarity
reduce frustration social/play communication requesting/help/advocacy AAC/total communication
other: _____

Any pertinent medical history or diagnosis within the family related to communication skills such as stuttering, autism and/or adhd diagnosis?

_____

_____

What is the child's daily schedule? Do they sleep through the night? Are they a picky eater? If so, please describe their regular diet. Any allergies or food sensitivities?

_____
_____
_____
_____

What is the child's birth history? Was the child born full term? If not, please specify gestational age, did the child spend time in the NICU? Were there any complications during pregnancy and/or birth?

_____
_____
_____

Is there any other information about your child or their developmental history that you would like to share?

Child Availability Form

Child's Name: _____

Instructions: Please check the boxes for the time slots that your child is available. Sessions are 30 minutes long and occur on the hour or half-hour.

Time Slot	Monday	Tuesday	Wednesday	Thursday	Friday
9:00 AM	[ ]	[ ]	[ ]	[ ]	[ ]
9:30 AM	[ ]	[ ]	[ ]	[ ]	[ ]
10:00 AM	[ ]	[ ]	[ ]	[ ]	[ ]
10:30 AM	[ ]	[ ]	[ ]	[ ]	[ ]
11:00 AM	[ ]	[ ]	[ ]	[ ]	[ ]
11:30 AM	[ ]	[ ]	[ ]	[ ]	[ ]
12:00 PM	[ ]	[ ]	[ ]	[ ]	[ ]
12:30 PM	[ ]	[ ]	[ ]	[ ]	[ ]
1:00 PM	[ ]	[ ]	[ ]	[ ]	[ ]
1:30 PM	[ ]	[ ]	[ ]	[ ]	[ ]
2:00 PM	[ ]	[ ]	[ ]	[ ]	[ ]
2:30 PM	[ ]	[ ]	[ ]	[ ]	[ ]
3:00 PM	[ ]	[ ]	[ ]	[ ]	[ ]
3:30 PM	[ ]	[ ]	[ ]	[ ]	[ ]
4:00 PM	[ ]	[ ]	[ ]	[ ]	[ ]
4:30 PM	[ ]	[ ]	[ ]	[ ]	[ ]
5:00 PM	[ ]	[ ]	[ ]	[ ]	[ ]
5:30 PM	[ ]	[ ]	[ ]	[ ]	[ ]

Parent/Guardian Signature: _____ **Date:** _____

Behavioral Precursors

A **precursor** is an event, action, or signal that occurs **before** a specific behavior and indicates that the behavior is likely to happen. Recognizing precursors helps our team anticipate and prevent challenging behaviors.

Please indicate if your child demonstrates any of the following behaviors when demands are placed on them:

- ☐ Spitting
- ☐ Kicking
- ☐ Hitting themselves or others
- ☐ Throwing objects
- ☐ Other (please specify): _____

Does your child display any precursors to these behaviors? Please describe:

Note: Speak Speech Therapy (SST) does **not** provide services from a **Board Certified Behavior Analyst (BCBA)** or a **Registered Behavior Technician (RBT)**.

If a behavior arises that is **outside of our clinical expertise**, SST will provide families with referrals to additional speech therapy companies for support.

Evaluations from Other Providers

- Speak Speech Therapy (SST) works directly with select ABA centers and daycare facilities.
- SST evaluations and school-based evaluations are conducted and processed differently.
- Any evaluations completed within the school district are the sole responsibility of the school district, and it is the responsibility of the school district's SLP to interpret evaluations completed in school settings.
- SST does not have the authority to interpret or provide recommendations based on evaluations completed in nonclinical settings, to include but not limited to school settings.
- SST SLPs may review reports or evaluations completed by other speech therapy providers. Sometimes, we may be able to use the information to guide treatment.
- However, making recommendations or interpreting results from outside reports will depend on each individual situation and will be decided by your child's supervising SLP.
- SST SLPs' findings are based solely on direct observations and results of assessments curated for each specific patient.
- SST retains the rights to its own evaluations and reports only.
- SST staff will not meet with school personnel, centers, or other entities with whom SST is not actively collaborating to discuss SST evaluations or findings, as school-based evaluations and clinic-based evaluations are two distinct assessment processes.

Billable Meetings and Parent Communication

- Parent communication is considered a billable service when an SST provider or SLP discusses treatment plans with families. This may include evaluations, reevaluations, AAC device planning, or therapy session discussions.
- SST will make every effort to bill the family's insurance for these services. However, if insurance denies coverage, the responsibility for payment falls to the parent/guardian.
- In such cases, a fee of **$65.00 per 30-minute session** will be billed directly to the family.
- SST verifies insurance coverage in good faith; however, the final determination of coverage is made by the insurance provide

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25420 Kuykendahl Rd. Ste F-300,
Tomball, TX 77375
Phone: 832-356-5152
Fax #: 832-201-0830

Office Hours: 8:30am- 5:00pm M-F

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Payment Policy

To ensure timely processing of patient financial responsibility and to support efficient billing operations, Speak Speech Therapy requires all accounts to maintain a valid payment method on file. Speak Speech Therapy does **not** accept cash payments.

Payment Method on File (Required)

A valid payment method on file is required for all active clients. Payment information is stored securely and is accessible only to authorized Speak Speech Therapy personnel for billing purposes.

No Cash Payments

Speak Speech Therapy does not accept cash payments for any services, fees, or balances.

Online Transaction Convenience Fee (3%)

In order to provide automatic billing, payment reminders, electronic receipts (e-receipts), and related online payment services, Speak Speech Therapy applies a 3% convenience fee to all online transactions. This fee helps offset the operational and administrative costs associated with providing these services.

Deposit for Initial Evaluation (Commercial Insurance Plans)

For any client covered by a **commercial health insurer**, a deposit will be collected at the time the initial evaluation is scheduled. The deposit amount varies by plan but will **not exceed $50**. This deposit will be applied toward the total cost of the initial evaluation.

Deposit refund eligibility: The deposit is only eligible for refund if the initial evaluation is cancelled **no later than 24 hours prior** to the scheduled evaluation time and the client does **not** wish to reschedule.

Initial Evaluation Cancellation Fee

Cancellation of an initial evaluation **within 24 hours** of the scheduled time will result in collection of an **additional $50**, for a total **$100 cancellation fee** for the evaluation.

Nonpayment and Interruption of Services

Services may be paused if there is nonpayment of any outstanding patient responsibility, including but not limited to copays, coinsurance, deductibles, or late fees. Any balance due remains the responsibility of the responsible party and must be paid in accordance with Speak Speech Therapy's billing practices.

Refunds and Account Credits

Refunds are issued only in instances of overpayment, except as otherwise stated above regarding the initial evaluation deposit. In the event of an overpayment, Speak Speech Therapy may apply the overpaid amount as an account credit toward future balances.

Acknowledgment: By signing this form, you acknowledge that you have read, understand, and agree to the terms of this Payment Policy Notice, including the requirement to maintain a payment method on file, the 3% convenience fee for online transactions, the initial evaluation deposit and cancellation terms, and Speak Speech Therapy's no-cash-payment policy.

Signature: _____ Date: _____

HIPAA POLICY
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. The right to inspect and copy your protected health information. The right to amend your protected health information. The right to obtain a paper copy of this notice from us upon request. This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-

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admin@speakspeechtherapy.com | 832-356-5152

Acknowledgement That You Have Received Our HIPAA Privacy Notice

Speak Speech Therapy is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
  Medical history
  Test results
  Treatment notes
  Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

☐ I acknowledge that I have received a copy of Speak Speech Therapy HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

☐ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

☐ I understand Speak Speech Therapy cannot disclose my health information other than as specified in the notice.

☐ I understand that Speak Speech Therapy reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client

Please Note: It is your right to refuse to sign this Acknowledgement.

HIPAA Privacy Notice Acknowledgement

Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s)

- An emergency prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgement.
- Other: _____

_____ _____

Staff Member Signature Date

info@speakspeechtherapy.com | 832-356-5152

Consent and Release of Photographs / Videos

☐ I, _____ (client or parent/guardian name) give consent to Speak Speech Therapy or any party authorized by Speak Speech Therapy to photograph and/or video record _____ (client name) in connection with his/her therapy sessions, for any purpose subject to the therapist's discretion including but not limited to educational publication, for teaching purposes, and demonstration of progression of his/her skills.

☐ I authorize Speak Speech Therapy to use pictures of _____ (client name)for promotional purposes (ex. brochures, website, etc.)

☐ I acknowledge that I will receive no financial compensation for providing consent since my participation with Speak Speech Therapy in providing my consent and release is voluntary.

☐ I hereby release Speak Speech Therapy, their contractors, their employees and/or any third parties involved in the creation or publication of Speak Speech Therapy. Publication from any and all liability that may arise in connection with the expressed and implied use of all photographs and videos outlined in this form.

☐ I reserve the right to revoke this agreement at any time. I understand that my right to revoke must be done in writing.

☐ I hereby release Speak Speech Therapy, their contractors, and employees permission to utilize Seesaw, email, text messages and other communication modalities to directly communicate with myself/parent/caregiver regarding their child's speech therapy services.

☐ **I do not give consent for my child to be photographed/filmed for any social media or other purposes.**

— I am the client, parent or legal guardian of the person named below and have the legal authority to execute this consent.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client

admin@speakspeechtherapy.com | 832-356-5152

Attendance / Cancellation Policy

Attendance and participation in therapy along with complete compliance with any associated home programs, are essential for therapeutic success.

While Speak Speech Therapy understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no shows". Please adhere to our following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, obligations for work or family, or any other event.

All cancellations must be submitted 24 hours prior to your scheduled appointment. **If a cancellation occurs less than 24 hours of a scheduled session, a $50.00 cancellation fee is charged.**

If you fail to appear for an appointment (no show) without providing the appropriate advance notice for 3 or more appointments within a 6-month period, Speak Speech Therapy reserves the right to discharge the patient from services.

☐ A 10 minute grace period is in effect for all services. Arriving more than 10 minutes after the scheduled session will result in a missed visit, and a cancellation fee of $50 will apply.

I,_____, understand the attendance / cancellation policy and the risks of not adhering to it.

_____ _____

Print Name of Patient Date

_____ _____

Signature of Guardian or Caregiver Relationship to Client

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25420 Kuykendahl Rd. Ste. F-300, Tomball, TX 77375

Phone: 832-356-5152, Fax: 832-201-0830

Surveillance Notice and Recording Consent

All SST clinic locations, including but not limited to Tomball and Southwest, are monitored by 24-hour video and audio surveillance for the purpose of ensuring the safety, security, and quality of care for clients, staff, and visitors. Surveillance may occur in common areas, hallways, therapy rooms, and other publicly accessible locations within the premises. By signing this admission paperwork, I acknowledge and consent to the use of continuous video and audio recording while on SST property. I understand that surveillance footage may be reviewed in the event of safety concerns, behavioral incidents, compliance audits, or property-related issues. This consent is provided in accordance with Texas Penal Code §16.02, which permits audio recording when at least one party to the conversation consents, and serves as notice that audio monitoring is in use. Surveillance recordings are maintained in a secure manner and will only be accessed by authorized personnel. I further understand that SST does not record in restrooms or other areas where a reasonable expectation of privacy exists. Consent to surveillance is a condition of receiving services at SST.

All SST clinic locations, including but not limited to the Tomball and Southwest offices, are equipped with 24-hour video and audio surveillance systems to ensure the safety, security, and quality of services provided to clients, staff, and visitors. Surveillance may occur in therapy rooms, hallways, and other common areas, excluding restrooms or private spaces where a reasonable expectation of privacy exists. In addition, during clinical supervision, there may be occasions when therapy sessions are video or audio recorded for educational, supervisory, and training purposes. These recordings are conducted in compliance with applicable state and federal laws, including Texas Penal Code §16.02, which permits audio recording with at least one-party consent. By signing this agreement, I acknowledge and provide informed consent to such surveillance and occasional recordings, understanding that these recordings are securely stored, accessed only by authorized personnel, and used strictly for clinical quality assurance, staff development, and training. Participation in SST services constitutes agreement to this policy and is required for ongoing treatment.

Parent/Guardian signature:_____ Date:_____

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Change of Provider Letter (If Applicable)

I, _____, parent/guardian of _____
Declare the following statements to be true.

-The decision to change therapy service providers was my own choice.
-Speak Speech Therapy personnel did not solicit me to change providers.
-I authorize Speak Speech Therapy to provide therapy services to the above-named child.
-I provide authorization to release any documentation to Speak Speech Therapy that they deem necessary for the continuance of care such as evaluation reports, Plan of care, authorizations, wellness visits, hearing test/screenings and letters of medical necessity.

Patient Medicaid ID #: _____
Patient Date of Birth: _____
Patient Primary Insurance: _____
Patient Secondary Insurance: _____
Reason for Change: _____
Service(s) to be transferred: _____ST (CPT 92507) _____OT (CPT 97530)
Current Agency Providing Service(s): _____
Last Date of services with Current Agency: _____
First date of Services with Speak Speech Therapy: _____

_____ _____
Parent/Legal Guardian Signature Date

admin@speakspeechtherapy.com | 832-356-5152

Authorization for Credit Card Use

By signing this form you give Speak Speech Therapy permission to debit your account for the amount indicated on or after the indicated date. This is permission for current and future services as outlined in this agreement, and does not provide authorization for unrelated debits or credits to your account. All clients are required to have a working card on file.

Name on Card: _____

Billing Address: _____

_____

Credit Card Type:

☐Visa ☐ Discover

☐Mastercard ☐American Express

☐FSA ☐Other _____

Credit Card Number:_____

Expiration Date: _____ Card Identification Number: ____ (3 digits on back of card)

I_____ (client or parent/guardian name) authorize Speak Speech Therapy to charge fees rendered for therapy services to the credit card provided herein.

Cardholder, please sign and date:

Print Name: _____

Signature:_____ Date: _____

Client Name: _____ Date of Birth: _____

Credit Card Authorization

I authorize Speak Speech Therapy to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for therapy services, for the amount invoiced by the practice, and is valid for ongoing monthly and weekly services. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

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Release of Information Form (PCP Recommended)

Client Name: _____ **Date of Birth:** _____

I_____**(client or family member) hereby grant** Speak Speech Therapy **permission to communicate with the following person or agency:**

Name: _____

Contact Information: _____

Information to Be Released: _____

- ☐ **ST** ☐ Medical History ☐ Billing Inquires ☐ Notes ☐ Evaluations
- ☐ **OT** ☐ Medical History ☐ Billing Inquires ☐ Notes ☐ Evaluations

Other: _____

For the Purpose Of: (check all that apply)

☐ Coordinating care with other professionals

☐ Providing continuity of services

☐ Updating therapeutic progress

☐ Other _____

☐ I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.

☐ I understand that unless revoked, this authorization will remain valid until written revocation of this authorization is presented.

Print Name Of Client _____ Date _____

_____ _____

Signature of Client or Legal Representative Relationship to Client

Authorization to Exchange, Obtain or Release Information

info@speakspeechtherapy.com | 832-356-5152

Consent for Observation

I, _____ (client or parent/guardian name) hereby grant Speak Speech Therapy and their consultants, contractors or employees to observe _____(client name) in the following setting(s):

Name of Location

☐ Day Care _____

☐ School _____

☐ Work _____

☐ Other: _____

☐ I Understand that during this observation, Speak Speech TherapyConsultants, their contractors, or their employee clinicians, teachers, employers, etc. may speak to providers about the client and I there by grant persion for such discussion.

☐ I am the client, parent or legal guardian of the person named below and have the legal authority to provide consent for observation.

Date: _____

_____ _____

Signature of Client or Legal Representative

Relationship to Client

info@speakspeechtherapy.com |832-356-5152

Acknowledgment & Assumption of Risk

☐ I, _____ (client or parent/guardian name) understand that I am being asked to carefully read each of the provisions in this form. I acknowledge and agree to have _____(client name) receive therapy services from Speak Speech Therapy and/or any employee or independent contractor employed by Speak Speech Therapy .

☐ I acknowledge that there is some inherent risks associated with the use of therapy equipment (including but not limited to: toys, books, swings, games) that cannot be eliminated regardless of the care taken to avoid injuries.

☐ I understand the risks and I hereby assert that my participation is voluntary and that I knowingly assume such risks without holding Speak Speech Therapy and/or any employee or independent contractor employed by Speak Speech Therapy accountable for any losses, injuries or other damages occurring to the client and/or myself. I further understand that I am fully responsible for my own safety.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client

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General Acknowledgment of Forms

☐ I hereby acknowledge and agree that I had read all of the forms and documents provided to me in connection with evaluation and treatment provided by Speak Speech Therapy and/or their employees.

□ I understand the meaning and intent of the provided forms and agree to all content included.

□ I have been given an opportunity to ask questions about the provided forms and all questions I've asked have been answered to my satisfaction by Speak Speech Therapy.

_____ _____

Print Name of Client Date

_____ _____

Signature of Participant or Legal Representative Relationship to Client