A+ PEDIATRICS

Welcome to A Plus Pediatrics and thank you so much for giving us the opportunity to participate in your child's care. We are excited to be a part of the Clermont community. To better serve you, please read and thoroughly complete our welcome packet.

Our providers are Dr. Angeles Otero, Dr. Melissa Valentin, Dr. Tonia Barton, Rachel Zakhary, APRN, Carrie Verhoff, APRN, and Melanie Snyder, APRN. All doctors are board certified and have hospital privileges at South Lake Hospital.

We will be able to see your children from birth and up until their 21st birthday although we do not accept new patients over 18 years old.

Office visits are by appointment only. In order to minimize waiting room time and provide you with the timeliest service possible, we do not accept walk-in visits. We will always try to schedule our sick patients within the same day or, at the latest, by the next business day. We do have extended hours until 7 pm to help those whose jobs may pose some scheduling challenges. We kindly ask you give us a 24-hour notice if you're not able to keep your appointment. Our office hours are the following:

Monday - Wednesday	8:00am - 7:00pm	
Thursday	7:30am – 7:00pm	
Friday	8:00am - 5:00 pm	(closed for lunch from 12-1pm)

Closed Saturday, Sunday, and holidays

Clinical messages during office hours are answered within the same business day (We encourage parents to send messages directly to your doctor through your portal account). After hours phone calls that are of an urgent nature will be handled by a provider from our office or a provider from South Lake Pediatrics. For these urgent matters you can reach an on-call doctor at (352) 235-5132. For appointments, refills, billing matters or non-urgent medical questions please call during regular office hours. Please note that it is our office policy not to call in prescriptions for illnesses that the patient has not recently been seen for, such as antibiotics. We cannot send refills or referrals if child's well visits are not up to date.

South Lake Pediatrics is affiliated with A Plus Pediatrics, and we may refer a sick patient to South Lake if we are unable to get your sick child in for a same day appointment at A Plus. Dr. Otero and Melanie Snyder, APRN see patients at both A Plus and South Lake Pediatrics.

Stay up to date by following us on Facebook, visiting and our website at www.apluspediatrics.com.

Thank you for choosing A Plus Pediatrics.

A+ PEDIATRICS

Today's Date _____

Please Print

Legal Patient Name: First _____ Middle _____ Last _____

Patient's Preferred Name: _____ Patient's Date Of Birth: _____ / _____ / _____

Sex: Male / Female (if applicable) Gender Identity/or other identifier _____

Siblings who are also patients here: _____

Patient Address: _____

City_____ State_____ Zip _____

Race/Ethnicity: _____ Language spoken at home _____-_____

Mother/Legal Guardian:_____ Father/Legal Guardian_____

DOB ____ /____ /_____ SS#_____-_____-_____ DOB____ /____ /_____ SS#_____-____-_____

Home Phone (_____) _____-_____ Home Phone (_____)_____-_____

Cell Phone (_____) _____-_____ Cell Phone (_____)_____-_____

Work Phone (_____) _____-_____ Work Phone (_____)_____-_____

Email: _____ Email: _____

Who is the primary contact? _____ Can we use the cell phone as primary number? Yes / No

Is it okay to leave messages including text reminder messages and lab results on your primary number? Yes / No

Do parents reside at same address? Yes / No If parents are divorced, who has legal custody? _____

Alternate Contact: _____ Phone:_____

Is Alternate Contact also an authorized person to bring in child? Yes / No If yes, Relationship: _____

Please give names and relationship of **anyone besides the above-named legal guardian** who has permission to bring your child in for medical treatment (the below mentioned person(s) you authorize to make medical decisions and have access to the patient medical record).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I acknowledge all information provided is correct. _____

Parent signature

Coordination of Benefits for Insurance Coverage

Throughout each year, your health insurance company may ask you to complete a form that verifies all health insurance available to you. Failure to complete this form can result in denied claims, even if you are only insured under one plan. **It is very important to thoroughly read and respond to all correspondence from your health insurance provider.**

If you have other insurance in addition to your primary coverage, we will need your other health insurance information to send to your primary insurance company (If you are separated, please verify with your ex-spouse if he/ she has the child under their policy). By coordinating benefits among all insurance carriers, our billing department will be able to bill your claims accordingly and potentially reduce your patient responsibility. If your insurance changes in the future, please call our office to update as soon as possible.

Primary Insurance Company Name: _____

PATIENT ›› Name of Patient: _____Date of Birth: _____

INSURED ›› Name of Insured:_____ Date of Birth: _____

Member/Subscriber ID#: _____ Group #: _____

Relationship to Patient: □ Self □ Spouse □ Parent □ Other: _____

***Does the Patient have other insurance or Medicaid Coverage?**

□ YES ›› Continue with form □ NO ›› Go to **Signature** section

Other Health Insurance Company Name: _____

Name of Subscriber: _____ Subscriber's DOB: _____

Member/Subscriber ID#: _____ Group #: _____

Relationship to Patient: □ Self □ Spouse □ Parent □ Other: _____

I certify the information provided is current and accurate and acknowledge that failure to provide the proper insurance information may delay the timely filing of medical claims for _____ which will result in the amount due becoming my financial responsibility.
Patient Name

Uninsured ONLY: I do not have insurance of any type and desire to pay "Self-Pay Rates" at time of service. I will notify office immediately if I obtain insurance. Initial _____

Insured but will not use Insurance: I elect not use insurance listed above but pay "Self-Pay Rates". Initial: _____

Parent Signature: _____ Today's Date: _____

Patient History

Patient Name: _____ Nickname(if any): _____

Date of Birth ___/____/_____ Gender: ____Male _____Female Race/ethnicity _____

Please circle : Is patient adopted Yes/ No Allergies to Medication_____

Birth History

Name and Location of Delivery Hospital:_____ ____Was it a vaginal delivery? _____

Where there any problems during pregnancy/delivery (please state)? _____

Did the mother smoke/drink alcohol/ use drugs or medications during pregnancy? _____

Was the baby more than 2 weeks premature or late(if so how many weeks)? _____

What was baby's weight at birth?_____ Any problems during nursery stay? _____

Development

Did baby sit by 7 months? ____ Did baby walk by 14 months? ____ Did baby say 3 words by 15 months? _____

Any school/developmental/discipline problems?_____

Please check off if patient has any of the following problems:

__bedwetting __sleep problems __ speech problems __problems with friends/peers

Social History

Name and age of mother _____ Name and age of Father_____

Name/age and sex of all siblings_____

_____

Who lives with patient?_____

Please circle: Are parents married/ divorced/ separated Are there any smokers in the home? _____

Is patient on any medications (OTC or prescription) or supplements?_____ If "Yes"please list _____

_____

Are there any home/domestic problems?_____

Medical/ Family History

Please check off whatever medical condition patient or family member has had (please state what relationship to patient example: sister, maternal grandmother etc...)

Wheezing/Asthma	__ patient	__ family _____
Eye/Vision problems	__patient	__family _____
Hearing Loss	__ patient	__ family _____
Frequent Ear infections	__ patient	__ family _____
Eczema/skin problems	__ patient	__ family _____
Allergies/ Hay Fever	__ patient	__ family _____
Anemia/Bleeding disorder	__ patient	__ family _____
Diabetes	__ patient	__ family _____
Seizures	__ patient	__ family _____
Kidney/Bladder problems	__ patient	__ family _____
High Blood Pressure	__ patient	__ family _____
ADD/ADHD	__ patient	__ family _____
Liver problems	__ patient	__ family _____
Mental/ Psychiatric Illness	__ patient	__ family _____
Alcohol/Drug Abuse	__ patient	__ family _____
Thyroid disease	__ patient	__ family _____
High Cholesterol	__ patient	__ family _____
Sudden/Unexplained Death	__ patient	__ family _____
Heart Disease	__ patient	__ family _____
genetic/inherited diseases	__ patient	__ family _____
cancer	__ patient	__ family _____
autism/aspergers	__ patient	__ family _____
Other_____	__ patient	__ family _____

Has your patient ever been prescribed a nebulizer machine?_____

Has anyone in the family had a heart attack/heart disease under the age of 50(who)? _____

Has Patient ever been hospitalized (please give date and illness)?_____

Has Patient had any surgeries (please give date and type of surgery)?_____

Has the patient had any serious illness or accidents?_____

Office Vaccine Policy

Here at “A Plus Pediatrics” we are committed to promoting the health and well-being of your child and we know without a doubt that every parent wants to do what is best for their child. The ability to prevent suffering is one of the things that means the most to us as pediatricians and pediatric providers. Today, most children in the United States lead much healthier lives and parents live with much less anxiety and worry over infections during childhood. Immunizations are one of the success stories of modern medicine. The science is overwhelming that vaccines are safe and effective. As such we do expect and require our patients to fully vaccinate according to the schedule and guidelines put out by the American Academy of Pediatrics and Centers for Disease Control because this protects your child/children and the community. We do want to acknowledge that there are concerns and some misinformation about vaccines and urge you to discuss these concerns during your child’s well visit.

In the following, we would like to ensure that you are aware of those vaccines that we consider imperative for our patients and we would like to give a very brief description of the illness that the vaccine prevents and age that the doses are recommended in the pediatric population. Please note that although MCV and Hepatitis A vaccines are not required for school these illnesses are either so prevalent in our community or so dangerous that we are requiring it at our office. VIS safety sheets are available upon request or on our website www.apluspediatrics.com. Thank you for taking the time to read this.

By signing you are agreeing to vaccinate per our office vaccine policy

Patient Name _____ Parents Name: _____

Parent Signature: _____

Required vaccines at “ A Plus Pediatrics”

____ **Diphtheria**: a bacteria that causes a thick coating in the back of the throat leading to breathing problems, possible heart failure and death. Dosage due: 2,4,6 and 15 months, then ages 4-6, 11 and 21. Comes in various forms (depends on age) our office uses the Pentacel, DTaP, and Tdap.

____**Tetanus**: bacteria that causes painful stiffening of muscle. Causes inability to swallow. Death occurs in 1/5 infected. Infection occurs from open wound. Dosage due: 2,4,6 and 15 months, then ages 4-6, 11 and 21. Dosage due: 2,4,6 and 15 months, then ages 4-6, 11 and 21. Comes in various forms (depends on age) our office uses the Pentacel, DTaP, and Tdap.

____**Pertussis:** Called whooping cough, a bacteria that can make it difficult to breathe. Can lead to pneumonia, brain damage and death. Dosage due: 2,4,6 and 15 months, then ages 4-6, 11 and 21. Comes in various forms (depends on age) our office uses the Pentacel, DTaP, and Tdap.

____ **Haemophilus influenzae type B (HIB):** Not to be confused with the flu; this is a bacteria that causes meningitis, pneumonia, infection in the blood and death. Dosage due: 2,4,6 and 15 months, comes in the Pentacel (combination vaccine) and as single vaccine (HIB).

____**Polio:** A virus that can cause mild symptoms but can progress to causing paralysis and death. Vaccine given at Dosage due: 2,4,6 and 15 months (optional dose), then ages 4-6. Comes in various forms (depends on age) our office uses the Pentacel, IPV, Kinrix (DTaP/IPV)

___**Pneumococcus:** This disease is caused by bacteria called Streptococcus pneumoniae. It causes ear infections, sinus infections, pneumonia, and even meningitis, making it very dangerous for children. Vaccine called PCV given at : 2,4,6 and 15 months.

___**Rotavirus:** Rotavirus is contagious and can cause severe watery diarrhea, often with vomiting, fever, and abdominal pain, mostly in infants and young children. Can cause severe dehydration and death. Vaccine: Oral (liquid) dosage given at 2,4 and 6 months.

___**Hepatitis B:** Virus that causes liver inflammation and possibly liver failure and death. Dosage given at: birth-1 month, 1-2 months and 6-9 months of age.

___**Hepatitis A:** Virus that causes inflammation of the liver. Dosage: given 6 months apart between ages of 12-24 months.

___**Measles:** Virus that causes fever, cough, runny nose, red eyes and rash. It can lead to brain swelling, pneumonia and death. Dosage given: 12 months and age 4-6 as MMR or MMRV.

___**Mumps:** A virus that causes fever, head and muscle aches, swelling of the salivary glands and tiredness. Can lead to meningitis and infertility. Dosage given: 12 months and age 4-6 as MMR or MMRV.

___**Rubella:** A Virus that causes fever, rash and swollen lymph nodes. In pregnant women can cause miscarriage. Dosage given: 12 months and age 4-6 as MMR or MMRV.

___**Varicella:** A virus that causes fever, and blistery rash. Can progress to inflammation in the brain, pneumonia and death. Dosage given: 12 months and age 4-6 as VZV or MMRV.

___**Meningococcus:** Bacteria that can lead to meningitis (inflammation of brain and spinal cord) and death. Often Leads to deafness and brain damage. Dosage given: MCV Age 11 and 16 (may be given earlier depending if traveling to certain countries).

Recommended but not mandatory vaccines: These will be offered at time of visit if/when appropriate.

____**Influenza:** virus that causes fever, body aches, headaches, cough and cold. Can lead to severe illnesses such as pneumonia and death. Dosage: yearly flu shot starting at age 6 months (first year of vaccine 2 doses given if under age9)

____ **HPV:** A virus that causes genital warts and can lead to cancer of the cervix, throat, penis, vagina and anus. Though it is mostly transmitted through sexual contact it can be spread by touch (not necessarily intercourse). This is the only vaccine so far that prevents cancer. Dosage given: 2 doses 6 months apart if started between ages 9-14. 3 doses required if vaccinating after age 15.

____**Men B:** A bacteria that is a bit rarer but can cause severe and deadly meningitis especially in higher risk groups. Dosage given: 6 months apart starting at age 16

Side effects: Common reactions occur in about 1 out of 4 children and include local redness, tenderness or swelling as well as fever and rash. This can last 2-3 days. For MMR/Varicella the reaction can occur 7-14 days after the vaccine is given. Teenagers are more prone to fainting after vaccines. Rotavirus may cause temporary vomiting and diarrhea typically mild. More rare but severe reactions 1/1 million can occur and include seizure, nervous system reaction, severe allergic reaction or non-stop crying. Getting the disease is more likely than the risk of severe vaccine reaction.

Contraindications to vaccines can include a weakened immune system, certain gastrointestinal problems, blood transfusions, severe allergy to neomycin, streptomycin, polymyxin, or yeast. Another contraindication is a severe reaction to a vaccine.

Financial Policy

1) New patient welcome packets must be completed prior to your being seen by the doctor. Verification of information will be updated on a yearly basis for established patients.

2) A Plus Pediatrics only bills insurance companies for which we are contracted providers. Please provide us with a current insurance card. You must notify us of any changes to your insurance prior to being seen by the doctor. If we cannot verify your insurance benefits you will be required to pay at the time of service or we will need to reschedule your visit.

3) We are required by our insurance contracts to collect co-pays or deductibles (if applicable) on the day of visit. Fees for tests and vaccines not covered under your insurance plan will also be collected on the day of service. Any shots that are in a series (i.e. Antibiotic or Allergy shots), may require a co-pay for each shot visit.

4) Managed Care and HMO insurance companies each have many different rules and regulations. Each also varies greatly on what visits, tests, vaccines, or procedures they cover. Because we participate in many plans, we cannot be responsible for ensuring your compliance with your insurance company rules. It is your responsibility to make sure you understand the terms and limitations of your insurance policy.

5) For new babies most insurance companies require that you add the baby to the policy within 30 days of his/her birth. Please call your insurance company to verify that the baby has been added to the policy prior to the visit to prevent any delays in medical care.

6) If your insurance carrier requires you to select a PCP, you must ensure that you have chosen us as your PCP prior to being seen. If you have not done so, let the office staff know so that we can assist you in this. If a claim is denied because you failed to select us as your PCP, you will be responsible for the claim.

7) Your insurance carrier is required to remit payment or provide a written response within (30) days of receipt of the claim. If a problem occurs with your claim, you will be asked to assist in resolving the issue.

8) If there are extenuating circumstances and you are unable to pay at the time of service, you may speak with the office manager and set up payment arrangements, but all arrangement balances are due in full 90 days from the date of service.

9) If for some reason your account becomes past due/delinquent, we will take the necessary steps to collect this debt. This may include referral to a collection agency or attorney; you will be expected to pay all collection and legal fees incurred. This may lead to discharge from the practice and you will be given 30 days' notice to establish medical care and during that time A Plus Pediatrics will only provide emergency care.

Print Name and Sign _____ / _____

Date _____

Consent and Authorizations

Patient Name:_____ DOB_____ Today's Date_____

Parent/Legal Guardian Name_____ Signature_____

I the undersigned, hereby authorize A Plus Pediatrics to render medical care to my child (self if over age 18). I authorize payment of medical benefits directly to A Plus Pediatrics and/or the attending physician for services rendered.

_____ Signature of Parent/Legal Guardian/Person responsible for account

I the undersigned, have received A Plus Pediatrics "**HIPAA** _Notice of Privacy Policies" detailing how my information may be used and disclosed as permitted under federal and state law. I authorize use/disclosure of information to coordinate and /or manage my child's (my if over 18) healthcare and any related services. I authorize A Plus Pediatrics to call my home or mail to my home any items that assist in the practice of carrying out treatment, payment and healthcare operations. I further understand that I have the right to request restrictions as to how my health information may be used or disclosed and that A Plus Pediatrics is not required to agree to these requested restrictions but if they do, the office is bound by this agreement.

_____Signature of Parent/Legal Guardian/Person responsible for account

I the undersigned have received A Plus Pediatrics "Financial Policy" and agree to abide by the terms set forth. It is my responsibility to provide A Plus Pediatrics with all necessary information to file insurance claims and to notify the office of any changes in coverage prior to any visits. I understand that my insurance policy is a contract between myself and my insurance company and that I am ultimately financially responsible for charges not covered by the policy. I understand it is my responsibility to know my insurance coverage and benefits including contracted laboratories/hospitals where my child may receive care. I understand that all co-pays, deductibles or patient percentages are due at the time of services rendered. I will assist in the collection of my insurance benefit should there be a delay in payment. In the event that my account becomes delinquent and must be turned over to a collection agency, I agree to pay any and all costs of collection including attorney fees.

_____Signature of Parent/Legal Guardian/Person responsible for account

706 E. Grand Hwy., Clermont, FL 34711 phone: 352-557-4965 fax: 352-404-6955

Notice of Privacy Policies

As Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you or your child (as a patient of A Plus Pediatrics) may be used and disclosed. We are dedicated to maintaining the privacy of your and/or your child's protected health information. At each visit to our office, an encounter form with all of the necessary information that is used to diagnose and treat you/your child will be added to the patient's medical record. Also, a bill will be created that will be sent to your insurance company for reimbursement of services rendered. Phone calls are also added to your medical records.

We may disclose you/your child's Health Information in the Following Ways

1) For Treatment: including labs, prescriptions, consultations with other health care providers, communication with health professionals that contribute to your care, appointment reminders, review of other treatment options/alternatives, available health benefits/services, business associates (such as radiology, ER or labs who are also required to safeguard your information), evaluation and improvement of care and quality of care. We may release your information to family and friends whom you have indicated in writing as directly involved in your child's care.

2)For Payment: Eligibility status, insurance billing (includes disclosure of diagnosis, procedures and supplies used), other third parties documented as responsible for costs.

3)For Legally Authorized Entities: Public Health institutions, Health Oversight Agencies (investigations/audits), FDA, Organ procurement organizations, Law Enforcement agencies, legally approved and authorized research institutions, court orders lawsuits and subpoenas.

4)Other: Funeral directors, workers compensation, obtaining interpreters when necessary, education of health professionals.

A Plus Pediatrics is required by law to maintain your privacy and we will not use your protected health information, without your authorization, in ways not covered under this notice. We reserve the right to change our practices and make new provisions effective for all protected health information we maintain. We will post a copy of your current notice in our office and you may request a copy of our most current Notice of Privacy Policies at any time.

We do request that you keep us updated to any change to your contact information to ensure delivery to the correct address, phone number and email.

You have the right to: 1) Inspect and receive a copy of your health records. 2)Amend your/your child's health records if you believe it is incorrect or incomplete (in keeping with HIPAA policies) . 3)Obtain an accounting of disclosures of the health records. 4)Request a restriction or revocation of health information records.

Please make requests in writing to our Privacy Officer, if you have any questions the privacy officer may be contacted by calling our office at (352) 557-4965.

If you believe your privacy rights have been violated, you can file a complaint with our privacy officer and/or with the Office for Civil Rights/ US dept of Health and Human Services at:

200 Independence Ave, S.W.
Room 509f, HHH Building
Washington D.C. 20201

Late Arrival Policy

Our doctors, medical assistants, and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy. If a patient is more than 15 minutes late for their appointment, you will be given the option to wait for the next appointment with the available provider or you may be rescheduled to another day. This is to ensure that the patients who arrive on time for their appointment do not wait longer than necessary. If you are late, we will try to accommodate you as best as possible, but we cannot compromise on the quality and timely care provided to our other patients.

Making and Keeping Appointments

When you make your appointment, please be sure to let our receptionist know the nature of your visit (ear pain, rash, complete physical, etc.). Also, please let us know at the time you schedule your appointment if you have multiple questions/concerns so we can allow enough time for your visit. Additional issues may need to be addressed in separate appointment. All follow-up appointments must be kept for quality of care, esp. ADHD and Asthma follow ups. Annual Well Visits and up to date vaccines are required to remain a patient in this practice.

No Show Policy

Please kindly give us notice by 8 am to reschedule or cancel your appointment for the same day. Cancellations may be left on our voicemail overnight. **Multiple ''No Shows'' may result in termination** of physician-patient relationship; this will be determined by the doctor.

The doctors and staff at A Plus Pediatrics truly appreciate your compliance and understanding with this policy so that we can continue to provide excellent medical care as well as excellent customer service.

Patient(s) Name_____

Parent Signature_____ Date _____

706 E. Grand Hwy., Clermont, FL 34711 phone: 352-557-4965 fax: 352-404-6955

Authorization for Release of Patient Health Information

Date___/___/_____

Medical facility Information requested from:		Information to be sent/given to:	
Physician Name	_____	Name:	A + Pediatrics_____
Address	_____	Address:	706 E. Grand Hwy___
	_____		Clermont, FL. 34711_
Phone No.	_____	Phone No:	(352)557-4965_____
Fax No.	_____	Fax No:	(352)404-6955_____

I _____ do hereby Authorize the release to A Plus Pediatrics of the following information from the medical records of:

Name_____ DOB_____

Information Requested: (Please note this authorization Expires 90 days after it is signed).

__**Complete Medical Records**
__Immunization record and any Pertinent Medical Record/ Problem list/ Growth Chart
__Hospital Records including labs and tests results
__Labs/ X-ray Reports
__Specialist Consultation
__Last visit and vaccination only
__Other/Please Specify _____

Parent Authorization

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulations 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as signed below. I UNDERSTAND that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection. **AS PART OF THE MEDICAL RECORDS CHECKED BELOW, THE FOLLOWING INFORMATIONWILL BE RELEASED ONLY BY MAIL OR PICK-UP UNLESS STRICKEN**: HIV/AIDS related information and/or records; sexually transmitted diseases; mental health information and/or records and drug/alcohol diagnosis, treatment or referral information.

*Initial by the following information you wish to be excluded from the records that are released.

____ Drug/ Alcohol abuse/treatment & Diagnosis
____ HIV/AIDS diagnosis/treatment/testing
____ Sexually transmitted disease/treatment
____ Mental illness or psychiatric diagnosis/treatment

My Rights

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view this process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Parent or Guardian Signature _____ Date: _____