Rose Street Mental Health Care - Spectrum
4084 S. Regent Dr.
Wichita Falls, TX 76308
Phone: (940) 224-5297 Fax: (940) 228-4025

Your Information, Your Rights, Our Responsibilities

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost based fee.
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.
- You can ask us **NOT** to use or share certain health information for treatment, payment, or our operations.
    - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full, you can ask us not to share that information for purpose of payment or our operations with your health insurer.
    - We will say "yes" unless a law requires us to share that information.
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- You can ask for a paper copy of this notice any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any actions.

Complaints

- You can complain if you feel we have violated your rights by contacting us using the information on the back of the page
- You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, DC 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

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- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Include your information in a hospital directory.

If you are unable to tell us preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will never share your information unless you give us written permission.

- Marketing purposes
- Sale of your information
- Most sharing or psychotherapy notes

Other Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

- We can use your health information and share it with other professionals who are treating you.
    - Example: a doctor treating you for an injury asks another doctor about your overall health condition.
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
    - Example: we use health information about you to manage your treatment and services.
- We can use and share your health information to bill and get payment from health plans or other entities.
    - Example: we give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in a way that contributes to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes, for more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
- We can use or share your information for health research
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with the federal privacy law.
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when a person is deceased.
- We can use or share health information about you:
    - For worker's compensation claims
    - For law enforcement purposes or with law enforcement officials
    - With health oversight agencies for activities authorized by law
    - For special government functions, such as military, national security, and presidential protective services

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- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Changes to the Terms of This Notice

We can change the terms of this notice and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. This Notice of Privacy Practices allies to the following organizations.

- Rose Street Clinic
- Rose Street Spectrum

Acknowledgement of Receipt of Notice of Privacy Practice

Please sign and date here stating you have received, read and understand the Notice of Privacy Practices.

_____ _____

Signature **Date**

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Informed Consent for Behavioral Services

The approach to behavioral intervention will utilize Applied Behavior Analysis (ABA) principles. ABA is the use of behavioral methods to measure behavior, teach functional skills, and evaluate progress. A unique plan will be created that results in long-lasting positive outcomes and an enhanced quality of life. Behavioral treatments are clinical processes that involve a professional arrangement. Laws, ethics, your rights as a client, and regulate therapy by standard business practices. Before intervention can begin, your agreement to the business practices described herein is required.

This document contains important information about Rose Street Spectrum's Applied Behavior Analysis (ABA) professional services and practice policies. It is important that you read through this information carefully and ask questions for clarification at any time. When you sign this document, it will represent an agreement between you and Rose Street Spectrum to provide ABA services.

This document describes the nature of the agreement for professional services, the agreed upon limits of those services, and rights and protections afforded under the Behavior Analyst Certification Board's Guidelines for Responsible Conduct of Behavior Analysts. I will receive a copy of this document to retain for my records. All fees for services and payment arrangements will be reviewed separately.

I, _____ [MR./MS. NAME], agree to have my child/dependent, _____[CHILD/DEPENDENT NAME], participate in applied behavior analysis (ABA) treatment services provided by providers employed with Rose Street Mental Health Care – Spectrum Program. I understand that the specific activities, goals, and desired outcomes of these ABA services will be fully discussed with me and that I will have the opportunity to ask for clarification prior to signing this document. I also understand that I have the right to ask follow-up questions throughout the course of service delivery to ensure my full participation in services. If these services have been arranged or will be paid for by a third party (e.g., school, insurance plan, state agency), I am aware that the third party has the following rights: determine services, review documentation of sessions for billing purposes, results of assessments, and written reports. I also understand that my child/dependent is the primary client of the behavior analyst and that services will be designed primarily for his/her benefit. Any other individuals or agencies (e.g., family, school professionals) that may be affected by the ABA services are considered secondary clients.

Possible Benefits Associated with Treatment

Multiple studies across decades of time have contributed to the current understanding of the benefits of Applied Behavior Analysis:

- Improvements in communication, social relationships, play, self-care, school, and employment
- Increased participation in family and community activities
- Improvements in "school readiness"
- Significant improvements (socially valid improvements) in learning, reasoning, and adaptability to change
- Studies have demonstrated that there is no age or diagnosis for which ABA services have no potential benefit, however it is well established that ABA has a greater impact when early intervention is provided for young children for young children (18 months to 5 years), and when delivered intensively (25-40 hours a week). Although individuals who receive intensive ABA treatment make larger improvements in more skill areas than do individuals who participate in other (non ABA) interventions.

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Possible Risks Associated with Treatment

Like many things in life, therapy/behavioral treatments have inherent risks. Some of these risks are:

- Disruptions in your daily life that can occur because of therapeutic changes
- No promises can be made regarding learner progress. Some individuals progress and learn skills quickly, while other learns take longer to learn skills or experience difficulty retaining skills once learned
- Emotional pain due to exploring personal issues and family history
- Emotional pain due to tolerating your child's reaction to behavioral intervention
- Initial increases in the duration, frequency, or intensity of problem behaviors due to the "Extinction Burst"
- Although treatment begins with the hope of behavioral improvement and positive outcomes in the overall family functioning, there is no guarantee that this will occur. There is, however, a better chance of improvement occurring if all caregivers in the household participate in the therapy.
- Across studies, a small percentage of individuals receiving ABA treatment show relatively little improvement. More research is needed to determine why some individuals respond more favorably than others. Currently it remains difficult to predict the extent to which an individual will benefit from ABA treatment

Treatment Termination

If at any time during the course of your treatment it is determined services cannot continue, a Transition to Termination notice can be provided to you explaining the justification for this decision. Ideally, services end when treatment plan goals have been achieved. Additional conditions of termination can include:

- You have the right to stop treatment at any time. If you make this choice, referrals to other therapists may be provided (if available).
- Professional ethics mandate that treatment continue only if it is reasonably clear you are receiving benefit. If it is determined that the services are not proving to be clinically beneficial, ethical conduct requires a termination of treatment.
- Other legal or ethical circumstances may arise and lead to termination of treatment, such as the clinical expertise of the Consultant being inappropriate or insufficient for the client/individual receiving treatment. Please note: the Consultant will not diagnose, treat, or advise on problems outside the recognized boundaries of his/her competencies.
- Other situations that warrant termination may include: drug abuse, disclosing illegal intentions or actions, inappropriate behavior during services, or failure to meet parent participation expectations.

Your signature will verify that you have read all of the information contained in this Informed Consent and that you asked questions about anything you have not understood up to this point.

By signing, you freely acknowledge your willingness to undergo treatment using Behavioral Therapy methods:

I acknowledge that therapy involves potential physical, emotional, and mental risks, including but not limited to the potential for property damage, personal injury, and emotional duress. I acknowledge that proper implementation of Applied Behavior Analysis requires ongoing training, supervision, and support from a Board Certified Behavior Analyst, adherence to the treatment plan, and diligence in data collection.

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These policies have been fully explained to me, and I fully and freely give my consent and permission for my dependent.

_____ _____

Parent or Guardian (legally authorized representative) **Date**

_____ _____

Parent or Guardian (legally authorized representative) **Date**

_____ _____

BCBA Certificate # _____ **Date**

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Additional Consents Request

Authorization to Release Information and Submission of Claims

I hereby authorize Rose Street Spectrum to submit claims for services covered under my insurance plan, on my behalf. By checking and initializing the box below, I give Rose Street Mental Health Care - Spectrum the authorization to bill said insurance directly and disclose any documents necessary to the insurance company for continued services.

_____ _____

Printed Name **Date**

_____ _____

Signature **Date**

Edible Reinforcement Utilization

The above information is true to the best of my knowledge. I authorize Rose Street Mental Health Care – Spectrum to utilize edible reinforcements that fall within my child's allergy and diet restrictions.

_____ _____

Printed Name **Date**

_____ _____

Signature **Date**

Emergency Assistance

I give the Rose Street Spectrum Program permission to administer First Aid/CPR on my child if an emergency arises.

_____ _____

Printed Name **Date**

_____ _____

Signature **Date**

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Behavioral Crisis Emergency Assistance

I give the Rose Street Spectrum Program permission to administer Safety Care on my child if a behavioral emergency arises that would place my child or other person at risk for injury.

_____ _____

Printed Name **Date**

_____ _____

Signature **Date**

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Rose Street Spectrum's Client Policies Revised

Billing & Payment Policy

It is your responsibility to know your insurance benefits, coverage, and limits for each service your child receives at the center. Billing occurs bi-weekly, and all co-pays must be paid specifically to your child's insurance/child's account to avoid any interruptions in service. Failure to pay amounts due will result in the possible suspension of therapeutic services if payment arrangements are necessary they can be established by contacting our administration assistants at 940-228-5297. Bill payments can be made in the form of cash, personal check, cashier's check, or credit card. Contact our administration assistance to assist with payments at 940-228-5297. Additionally, you will be responsible for paying any returned check fees.

Patient Eligibility Waiver & Financial Responsibility

The purpose of this form is to help our patients understand about medical insurance, eligibility, coverage, our office policy, and medical services.

It must be understood that:

- We render our services on the basis that insurance companies may or may not pay for all, or a portion of our charges.
- Authorizations for treatment from your insurance company does not guarantee full payment for the service.
- Not all insurance companies/third party payers pay for all services; each policy has its stipulations regarding covered services or amount of coverage.
- All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Your insurance company determines actual benefits after a claim is received.
- Patients are personally responsible for Knowing and Understanding their Insurance Policy, Eligibility, and Coverage.
- Patients are responsible for payment of outstanding Deductibles and Co-insurance amounts at the time of service. Co-payments will be collected at the time of service.
- Patients are financially responsible for payments of all non-authorized procedures and non-covered services.
- Any appointment missed or not canceled more than 24 hours in advance will incur a $25.00 charge
- Returned checks are subject to a $25.00 fee.
- Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.

The Patient or Patient's Legal Representative at this moment acknowledges that he/she is Eligible for Health Insurance Benefits and Coverage. That in the event of ineligibility for coverage of plan benefits, as well as all non-authorized procedures and non-covered services, he/she understands and agrees to be fully financially responsible for payment of all costs incurred during the delivery of health services, and agrees to pay all charges to the Center accordingly.

_____ _____

Signature of Patient or Guardian **Date**

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*Notice of any observed holidays will be provided at the beginning of each month for you to make the appropriate arrangements. Please note, the Spectrum may close unexpectedly due to inclement weather or another emergency to provide the safest environment for your children.

Rates

Quality of service is of the utmost importance to the staff at Rose Street Spectrum. Our team of Case Managers and Assistant Case Managers includes individuals who are certified and those who are steadily working towards their certification by the Behavior Analysis Certification Board. The standard billing rate for each level of therapist employed by Rose Street Spectrum is set to provide quality services at an affordable rate.

Required Parent Involvement

Parent involvement is essential to the success of our students. All parents are required to attend at least one (1) meeting each quarter with their child's supervisor for a minimum of 60-minutes. It is the parent's responsibility to arrange these meetings with the administrative assistant, to coordinate both the supervisor and the parents' availability. This will give you the opportunity to be informed about the program your child has worked on, the progress made, and any concerns you may have.

Open Door Policy

Observation of ABA therapy will be made available in the open gym and the child's selected 1:1 training area. Please notify your therapist in advance, so that we may transition any child whose parent has not authorized observation out of the area to ensure that we protect their rights and confidentiality. During these times, parents can observe their child's progress and take notes on therapeutic procedures/programs. You are welcome to observe your child's entire session or observe only a part of the session, so long as it is not disruptive to the therapeutic process for your child and other children receiving services. A waiting room is available when you are no longer observing your child, or you may leave and return to pick your child up when his/her session is finished. Please plan arrangements for your other children when you are observing. It is possible that their presence will distract other children in the clinic. Children of any age cannot be left unattended. Cell phones must be put away and turned to silent during observation to maximize our efforts. Observation of social groups is by appointment only. Some of our children are sensitive to major changes in their environment or schedule, such as a new adult in the room, and such a change may need to be introduced rather than spontaneous. Thank you for understanding. Please note that our open-door policy remains as a time for you to observe your child and take notes. Unless you have set up an appointment for a session with your child's Case Manager, please refrain from "over questioning" the Registered Behavior Technician working with your child during this time. If you have a question about the programming or procedure, please wait and email your child's Case Manager and he/she will be able to help you.

Policy on Unattended Children

Rose Street Spectrum requires that a caregiver over the age of 18 be present always while a Tutor or a Consultant is engaged in an in-home or community-based session.

Community-Based Intervention

Your child may have the opportunity to participate in the community-based intervention. During these times you will be required to transport your child to and from the activity. Additionally, your attendance might be necessary on a case-by-case basis.

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I AGREE FOR ROSE STREET SPECTRUM TO ENGAGE IN COMMUNITY-BASED INTERVENTION. By agreeing to this waiver, I do not hold Rose Street Spectrum or its affiliates responsible for any injury, damage of property, or other unforeseen incidents that occur during the community-based intervention (including the recognition of my limits to confidentiality during such intervention seeing that it is public).

_____ _____

Parent/Legal Guardian Signature **Date**

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Medicines

We do not administer medications without a doctor's orders. Please give the doctor's orders to the therapist, along with the medication in a Ziploc bag labeled with the name of the child. A parent or guardian will be required to fill out a medical release form as well. Your therapist will provide you with the necessary form.

Attendance

Because progress is dependent on consistent attendance, each child must attend therapy on a regular basis. In fairness to both the children enrolled and those children on our waiting list, any child with more than three consecutive unexcused absences, or any child with variable/reduced attendance rates, may be removed from the roll. Parents should call the main office before any missed session to report illness or other valid reasons for absence. Extended or excessive absences are not acceptable. The Executive Staff will review valid excuses and extenuating family circumstances, with decisions about continued enrollment made on an individual basis.

Late Policy

Therapy sessions have a specified start and end time. We cannot accommodate children left past their scheduled therapy sessions. If you are late picking up your child, you will be charged one dollar ($1) for every minute you are late. The fee will be added to your next invoice regardless of your insurance. Additionally, it is important that your child is on time for their session or group. It is disruptive for children to arrive late and they miss their therapy time. There will be no proration or make-ups for late arrivals.

_____ _____

Parent/Legal Guardian Signature **Date**

Communication Policy

If you do not already have an email address, please set one up. Email is our main point of contact with each family. You will be receiving important notifications through email. It is also the most efficient way for you to communicate with us. All appointments, schedule changes, and meeting requests must be made to your child's direct supervisor or our general email (wfspectrum@gmail.com). Please make sure your email will accept email from the following: wfspectrum@gmail.com. In the event of inclement weather, we will give information regarding closing via email. If you are unsure if we are open, you can check the local news for updates as well as email us directly to get that information. We will also do our best to post closings with the major news stations. You should also check our Facebook page for up to the minute updates at www.facebook.com/rosestreetspectrum.

Communication Email Waiver

E-mail offers an easy and convenient way for clients and service providers to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember: there are important differences. E-mail is different from calling our office; there is no person at the other end of the call – just a computer. You can't tell for certain when your message will be read, or even if the recipient is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to client

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care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us using e-mail:

- E-mail is never, ever, appropriate for urgent or emergency problems. Please use the telephone or go to the Emergency Department for emergencies.
- E-mail is great for asking those little questions that don't require a lot of discussion. Appropriate uses of e-mail also include appointment scheduling requests and billing/insurance questions.
- E-mail is not confidential. It is like sending a postcard through the mail. My staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
- E-mail may become a part of the medical record when we use it; a copy may be printed and put in your chart.
- E-mail is not a substitute for direct participation in client treatment (i.e. Family Participation Contract). If you think that you might need time to discuss concerns face to face, please call, and book an appointment.
- E-mails may be forwarded to my staff for handling, if appropriate.

Communication Waiver

☐ *I DO NOT want to communicate with my Rose Street Spectrum service providers electronically. I have read and understand the above information transmitted.*

☐ **I give the Rose Street Spectrum Program permission to** *communicate with me electronically. I have read the above information and understand the limitations of security on information transmitted.*

_____ _____

Parent/Legal Guardian Signature **Date**

Photo/Video Consent and Release

The Rose Street Spectrum program utilizes a variety of different digital devices to monitor your child's progress (video, audio, and photograph). The products of these devices maintain confidential standards and are not released without the explicit permission of the parent/guardian. By signing the below consent form, you are granting Rose Street Spectrum exclusive rights and use of these products for training, professional, and advertising purposes.

Regarding my child's participation at the Rose Street Spectrum program, I hereby authorize and give my consent for Rose Street Spectrum program to use their collection of digital products (video, audio, and photograph) of my child. This consent grants the Rose Street Spectrum program exclusive rights of these products without payment or other consideration made to me. These digital products may be printed in newspapers, magazines, websites (private and social), commercials and other forms for advertising, training, or professional purposes. I agree that these photos are the property of Rose Street Spectrum program and may be used at any time until I withdraw my consent in writing.

I certify that by checking the CONFIRM box below and entering my initials below on this release and consent form gives permission to Rose Street Spectrum the full right to use my child's photograph(s) and/or videotaped image(s) and sound byte(s) in its staff

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training, educational seminars, and promotional efforts (including brochures and company social networking sites). I willingly agreed to have my child's photograph(s), videotaped image(s), and sound byte(s) taken knowing that it could be used in various publications and/or broadcasts in the State of Texas and/or throughout the United States.

- ☐ *I acknowledge that I have read the above information and understand my rights and **I DO NOT** want Rose Street Spectrum program to use their collection of digital products (video, audio, and photograph) of my child in newspapers, magazines, websites (private and social), commercials and other forms for advertising, training, or professional purposes. I have read and understand the above information transmitted.*

- ☐ *I acknowledge that I have read the above information and understand my rights and **I** **give the Rose Street Spectrum Program permission to** use their collection of digital products (video, audio, and photograph) of my child in newspapers, magazines, websites (private and social), commercials and other forms for advertising, training, or professional purposes. I have read the above information and understand the use of their collection of digital products (video, audio, and photograph) of my child in newspapers, magazines, websites (private and social), commercials and other forms for advertising, training, or professional purposes.*

_____ _____

Parent/Legal Guardian Signature **Date**

Participant Agreement, Release, and Liability Waiver (The Agreement)

PARTICIPANT NAME/DOB:		
PARENT/LEGAL GUARDIAN NAME:		
CELL:	EMAIL:	EMERGENCY CONTACT/NUMBER:
ADDRESS:		

In consideration for participants permission to utilize gym equipment (to include trampoline, therapy swings, wheeled scooters, bikes, and tricycles, and all other gym equipment) located at 3501 Sheppard Access Rd Wichita Falls, TX 76306 (“Location”) and engaging the services of Rose Street Spectrum (Rose Street Mental Health Care), their agents, owners, officers, directors, representatives, assigns, affiliates, volunteers, participants, employees, insurers, and all other persons or entities acting in any capacity on their behalf, (herein after collectively referred to as “Rose Street Spectrum”), I on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representatives, estate, and insurers, agree as follows:

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(Initial Here) _____ I acknowledge that my participation in Rose Street Spectrum trampoline games or gym activities entails known and unanticipated risks that could result in physical or emotional injury including, but not limited to broken bones, sprained or torn ligaments, paralysis, death, or other bodily injury or property damage to myself my child(ren), or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity. I expressly agree and promise to accept and assume all the risks existing in this activity. My and/or my child(ren)'s participation in these activities is purely voluntary and I elect to participate, or allow my children to participate despite the risks. If I and/or my child(ren) are injured, I acknowledge that I or my child(ren) may require medical assistance, which I acknowledge will be at my own expense or the expense of my personal insurer(s). I hereby represent and affirm that I have adequate and appropriate insurance to provide coverage for such medical expense. I UNDERSTAND AND AGREE THAT ROSE STREET SPECTRUM WILL NOT PAY FOR ANY COST OR EXPENSES INCURRED BY ME IF I AND/OR MY CHILD ARE INJURED UNLESS SUCH INJURY WAS CAUSED BY GREATER THAN ORDINARY NEGLIGENCE OF ROSE STREET SPECTRUM. In consideration of Rose Street

Spectrum allowing my participation in trampoline games or gym activities, I for myself and on behalf of my child(ren) and/or legal ward, heirs, administrators, personal representatives, or assigns, do agree to hold harmless, release and discharge Rose Street Spectrum of and from all claims, demands, causes of action, and legal liability, whether the same be known or unknown, anticipated or unanticipated, due to Rose Street Spectrum's ordinary negligence: and I, for myself and on behalf of my child(ren) and/or legal ward, heirs, administrators, personal representatives, or any assigns, further agree that except in the event of Rose Street Spectrum's gross negligence and willful and wanton misconduct, I shall not bring any claims, demands, legal actions and causes of action, against Rose Street Spectrum for any economic and non-economic losses due to bodily injury, death, property damage sustained by me and/or my minor child(ren) that are in any way associated with Rose Street Spectrum trampoline games or gym activities. Should Rose Street Spectrum or anyone acting on their behalf be required to incur attorney's fees and costs to enforce this Agreement, I for myself and on behalf of my child(ren), and/or legal ward, heirs, administrators, personal representatives or assigns, agree to indemnify, and hold them harmless for all such fees and costs.

(Initial Here)_____ I certify that I and/or my children are physically able to participate in all activities at the Location without aid or assistance. I further certify that I am willing to assume the risk of any medical or physical condition that I and/or my children may have. I acknowledge that I have read the rules, (the "Rose Street Spectrum Rules") governing my and/or my child(ren)'s participation in any activities at the Location. I certify that I have explained the Rose Street Spectrum Rules to the child(ren) listed in this waiver. I understand that the SZITP Rules have been implemented for the safety of all guests at the Location, including myself and/or my child(ren). I acknowledge that failure to follow the rules could result in the expulsion of myself and/or my child(ren) from the Location. I agree that if any portion of this Agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect. If there are any disputes regarding this agreement, I on behalf of myself and/or my child(ren) hereby waive any right I and/or my child(ren) may have to a trial and agree that such dispute shall be brought within one year of the date of this Agreement and will be determined by binding arbitration before one arbitrator pursuant to its Comprehensive Arbitration Rules and Procedures. I further agree that the arbitration will take place solely in the state of Texas and that the substantive law of Texas shall apply.

I further grant Rose Street Spectrum the right, without reservation or limitation, to videotape, and/or record me and/or my child(ren) for therapeutic purposes.

By signing this document, I acknowledge on behalf of myself and the participants listed in this Agreement (collectively, "Participant") that if any Participant is hurt or property is damaged during the Participant's participation in this activity, pursuant to this Agreement, the Participant has waived the right to maintain a lawsuit against Rose Street Spectrum based on any claim

Rose Street Mental Health Care - Spectrum
4084 S. Regent Dr.
Wichita Falls, TX 76308
Phone: (940) 224-5297 Fax: (940) 228-4025

from which the Participant has released Rose Street Spectrum herein. I further acknowledge that I have had sufficient opportunity to read this entire document. I understand this Agreement and I, on behalf of myself and the participants listed in the agreement, I voluntarily agree to be bound by its terms.

I further certify that I am the parent or legal guardian of the child(ren) listed above on this Agreement or that I have been granted power of attorney to sign this Agreement on behalf of the parent or legal guardian of the child(ren) listed above. If I do not have the requisite authority to sign this Agreement on behalf of the child(ren) listed above, I agree that I shall be solely liable for any and all actions, causes of actions, penalties, claims, costs, services, compensation or the like resulting from this misrepresentation. I agree to be contractually bound by this certification.

_____ _____

Parent/Legal Guardian Signature **Date**