125 Dillmont Drive, Columbus, Ohio 43235
Phone: 614-844-5433 Fax: 614-987-8643
Email: therapy@thelearningspectrum.com

The Learning Spectrum Therapy Clinic

Client Information

Name: _____ Today's Date: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Contact Information:

Parent/Guardian Name: _____

Email: _____

Cell #: _____ Home #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

Referral Information:

Primary Care Physician's Name: _____

Primary Care Physician's Address: _____

City: _____ State: _____ Zip: _____

Physician's Fax Number: _____

Physician's Phone Number: _____

Medical Information:

Medical Diagnosis: _____

Medications: _____

Allergies: _____

Diet Restrictions: _____

Safety Protocols (ex. Seizures, elopement risk, etc):

_____

_____

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Payment Information

Therapy Funding Source: ☐ Self-Pay ☐ Insurance ☐ Medicaid ☐ DCBDD
☐ Autism Scholarship ☐ School District
☐ Other: _____

Person Responsible for Payment: _____

Payment Address (if different than client): _____

City: _____ State: _____ Zip: _____

Payment Phone Number (if different than client): _____

Insurance Information

Please complete the following section only if you would like The Learning Spectrum to submit insurance/Medicaid claims for services provided on your behalf.

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD / MEDICAID CARDS.

Primary Insurance: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Group Number: _____ ID Number: _____

Insurance Address: _____

Phone Number: _____

Visit Copay: $_____

Client's Relationship to Policy Holder: _____

Secondary Insurance: _____

Policy Holder Name: _____

Group Number: _____

ID Number: _____

Phone Number: _____

Client's Relationship to Policy Holder: _____

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Emergency Information

Child's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Parent/Guardian: _____

Phone: _____ Email: _____

Parent/Guardian: _____

Phone: _____ Email: _____

Emergency Contacts:

1. Name: _____ Phone Number: _____

   Relationship to the child: _____

2. Name: _____ Phone Number: _____

   Relationship to the child: _____

Authorization is hereby given to The Learning Spectrum staff to release the above-named child to the following persons, provided proper identification.

1. Name: _____ Relationship: _____

2. Name: _____ Relationship: _____

3. Name: _____ Relationship: _____

Physician to be contacted in an emergency:

Name: _____ Phone Number: _____

Specific Diet Restrictions: _____

Additional Medical Information: _____

I, the undersigned, authorize the staff of The Learning Spectrum to take what emergency medical measures are deemed necessary for the care of my child enrolled at The Learning Spectrum.

Parent/Guardian Signature: _____ Date: _____

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Therapy Department

Client History and Concerns

Child's Name: _____ Parent's Name: _____
Child's School: _____ School Grade: _____
Siblings (names & ages):
_____
_____

1. What is your child's medical diagnosis?
☐ My child does not have a medical diagnosis
☐ My child's diagnosis is:
_____
_____
_____

2. What therapy services are you interested in?
☐ Speech therapy
☐ Occupational therapy
☐ Music therapy

3. What therapy services has your child *previously* received?
☐ Speech therapy at: _____
☐ Occupational therapy at: _____
☐ Physical therapy at: _____
☐ Music therapy at: _____
☐ Feeding therapy at: _____

4. What therapy services is your child *currently* receiving?
☐ Speech therapy at: _____ Day/Time: _____
☐ Occupational therapy at: _____ Day/Time: _____
☐ Physical therapy at: _____ Day/Time: _____
☐ Music therapy at: _____ Day/Time: _____
☐ Feeding therapy at: _____ Day/Time: _____

5. Is English the only language spoken in the home?
☐ Yes
☐ No (specify): _____

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6. Please indicate all means of communication your child currently uses:

☐ Speech	☐ Manual Signs	☐ Pointing
☐ Facial Expressions	☐ Crying	☐ PECS
☐ Spoken (yes/no)	☐ Gestures	☐ Echolalia
☐ Gestural (yes/no)	☐ Physical leading	☐ Vocalizations (sounds)

☐ Augmentative Communication Device (specify): _____

7. Please provide an example of how your child communicates wants/needs:

_____

_____

_____

8. Has your child had any surgeries?

☐ No

☐ Yes (please specify):

_____

_____

9. Has your child had any major accidents or hospitalizations?

☐ No

☐ Yes (please specify):

_____

10. Has your child had any difficulties with vision?

☐ No

☐ Yes (please specify):

_____

11. Has your child had any difficulties with hearing?

☐ No

☐ Yes (please specify):

_____

12. Has your child had frequent ear infections?

☐ No

☐ Yes

13. Has your child had ear tubes?

☐ No

☐ Yes

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Developmental History

Please provide the approximate age (or n/a) at which your child began to do the following activities:

Crawl: _____ Sit: _____ Stand: _____
Walk: _____ Feed self: _____ Dress self: _____
Use toilet: _____
Use single words (e.g. mom, doggie, no): _____
Combine words (e.g. me go, daddy shoe): _____
Name simple objects (e.g. dog, car, tree): _____
Use simple questions (e.g. Where's doggie?): _____
Engage in a conversation: _____

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Please complete the following with a brief description of your concerns for your child's development and functioning in the following areas:

1. **Language** - *uses words and sentences expected of his/her age, uses and understands age-appropriate grammar and vocabulary, uses language to get basic wants and needs met, understands what is said to him/her and follows directions.*
   ☐ Not a concern at this time
   ☐ Not sure
   ☐ This is a concern

   Please explain: _____

2. **Social skills** - *participates in conversation, uses appropriate eye contact, uses and understands nonverbal language, seeks out interaction with others, understands the perspective of others.*
   ☐ Not a concern at this time
   ☐ Not sure
   ☐ This is a concern

   Please explain: _____

3. **Play skills** - *plays with a wide variety of toys and other children in an age appropriate manner.*
   ☐ Not a concern at this time
   ☐ Not sure
   ☐ This is a concern

   Please explain: _____

4. **Articulation** - *produces sounds when speaking in an age appropriate manner and is easily understood by others.*
   ☐ Not a concern at this time
   ☐ Not sure
   ☐ This is a concern

   Please explain: _____

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5. **Behavior** - *transitions between activities, follows rules and social expectations, handles disagreements and problems in age-appropriate ways.*
   ☐ Not a concern at this time
   ☐ Not sure
   ☐ This is a concern

   Please explain: _____

6. **Feeding** - *eats a wide range of foods from all food groups and tries new foods with little difficulty, eats with age appropriate utensils, has no difficulty chewing and swallowing.*
   ☐ Not a concern at this time
   ☐ Not sure
   ☐ This is a concern

   Please explain: _____

7. **Self-help Skills** – *dressing, bathing, self-feeding, handwashing, toileting.*
   ☐ Not a concern at this time
   ☐ Not sure
   ☐ This is a concern

   Please explain: _____

8. **Fine motor** - *handwriting, cutting, tying shoelaces, keyboarding, small closures (buttons, snaps, zippers).*
   ☐ Not a concern at this time
   ☐ Not sure
   ☐ This is a concern

   Please explain: _____

9. **Gross motor** - *walking, jumping, running, bicycling, climbing stairs, balance/coordination.*
   ☐ Not a concern at this time
   ☐ Not sure
   ☐ This is a concern

   Please explain: _____

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10. **Sensory** - *tolerates sensory input from the environment, including, but not limited to a variety of sounds, light, smells, touch, and movements. Does not have issues with clumsiness, or ability to sit still.*
    - ☐ Not a concern at this time
    - ☐ Not sure
    - ☐ This is a concern

    Please explain: _____

11. Please check the social skills that you feel your child struggles with:
    - ☐ Greetings
    - ☐ Farewells
    - ☐ Turn-Taking
    - ☐ Play Skills
    - ☐ Eye Contact
    - ☐ Protesting
    - ☐ Initiating Conversation
    - ☐ Identifying Emotions
    - ☐ Maintaining Conversation
    - ☐ Understanding Gestures / Facial Expressions
    - ☐ Perspective Taking
    - ☐ Following Directions
    - ☐ Asking Questions
    - ☐ Commenting

12. How well does your child understand what is said to him/her?
    - ☐ Understands gestures
    - ☐ Understands single words
    - ☐ Understands 2 & 3 part commands
    - ☐ Does not understand spoken words
    - ☐ Understands simple sentences
    - ☐ Understands conversation

13. What (if any) special equipment does your child use?
    - ☐ Wheelchair
    - ☐ Eyeglasses
    - ☐ Hearing Aides
    - ☐ Braces/Orthotics
    - ☐ Walker
    - ☐ Communication Device
    - ☐ Other _____

14. Please select any sensory processing tendencies that you feel describe your child:
    - ☐ Frequently trips, or appears clumsy
    - ☐ Is overly sensitive to clothing tags or textures
    - ☐ Is overly sensitive to touch, noise smells, etc.
    - ☐ Has difficulty transitioning between tasks
    - ☐ Is fearful of swings or other playground structures
    - ☐ Walks on toes
    - ☐ Is in constant motion
    - ☐ Mouths nonfood items
    - ☐ Has trouble sitting still
    - ☐ Bumps into other people

15. Please select any of the following self-help skills your child has difficulty with:
    - ☐ Putting clothes on
    - ☐ Taking clothes off
    - ☐ Putting socks on
    - ☐ Taking socks off
    - ☐ Putting shoes on
    - ☐ Taking shoes off
    - ☐ Fasteners (buttons, zippers, snaps)
    - ☐ Opening containers
    - ☐ Brushing teeth
    - ☐ Washing hands
    - ☐ Brushing hair
    - ☐ Toileting

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What are your child's strengths?

_____
_____
_____

What motivates your child?

_____
_____
_____

In what areas do you need assistance to best support your child in his/her home, school, and community?

_____
_____
_____

Does your child engage in any behaviors that we need to be aware of, or that you would like us to address?

_____
_____
_____

What is your primary goal in therapy?

_____
_____
_____

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Preference Checklist

Activities

☐ Blowing Bubbles ☐ Puzzles ☐ Playing with Play-Doh ☐ Playing peek-a-boo
☐ Video Games ☐ Swinging ☐ Playing with water ☐ Writing or Drawing
☐ Jumping ☐ Coloring ☐ Singing ☐ Rough-housing or Wrestling
☐ Dancing ☐ Running ☐ Rocking in a chair ☐ Playing or throwing ball
☐ Climbing on playground equipment ☐ Games (specify): _____
☐ Listening to music (specify): _____
☐ Looking at books/magazines (specify): _____
☐ Looking at pictures (specify): _____
☐ Computer Games (specify): _____
☐ Watching TV or Movies (specify): _____
Other activities your child enjoys? _____

Objects

☐ Puzzles ☐ Stickers ☐ Rubber Stamps ☐ Blocks
☐ Trains ☐ Legos ☐ Toy Cars or Trucks ☐ Stuffed Animals
☐ Scented Lotions ☐ Toys that Spin ☐ Toys that Light Up ☐ Toys that play music or talk
☐ Toy Animals (specify): _____
☐ Dolls or Figurines (specify): _____
Other objects your child enjoys? _____

Edible Reinforcers

☐ Popcorn ☐ Pudding ☐ Popsicles ☐ Gum
☐ Drinks (specify): _____
☐ Chips / Crackers (specify): _____
☐ Cookies / Candy (specify): _____
Other foods your child enjoys? _____

Other

☐ Verbal Praise ☐ Smiles ☐ Hugs ☐ Tickles
☐ High Fives ☐ Positive Note Home
☐ Special Jobs (ex. Vacuuming): _____

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Therapy Clinic

Attendance and Cancellation Policy

At The Learning Spectrum, we understand that therapy sessions may sometimes need to be canceled due to illness, family emergencies, vacations, weather, etc. In the event that you must cancel a session, please refer to the following policies:

Attendance and Cancellation Policy

- In the event that a therapist must cancel a session, every effort will be made to schedule a make-up session for your child. If you must cancel a session in advance, you are required to discuss scheduling a make-up session with your child's therapist.
- If a client is unable to maintain 75% attendance for scheduled sessions, he/she may be discharged from therapy services.
- 2 "no call/no shows" and failure to contact your child's therapist to schedule a make- up session will result in discharge from therapy services.
- Parent/caregiver must notify therapist of cancellation 24 hours in advance of session. Failure to do so will incur a cancellation charge of **$100/hour**, charged to the parent.
- Therapists should be notified directly of cancellations. You may leave a voicemail at 614-844-5433, or send an email directly to your child's therapist. Please do not assume that other teachers or staff members will notify your child's therapist.
- 30 days' notice is required before a client discontinues therapy services. Without notice, the client will be billed personally for the remainder of the 30 days, or until a new client is scheduled to take their place

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Therapy Department

Notice of Attendance and Cancellation Policy

I, _____, parent/guardian of _____,

(print name) (client's name)

state that I have received a copy of the attendance and cancellation policy. I have read the policy, and I understand all expectations outlined within.

Parent/Guardian Signature: _____ Date: _____

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The Learning Spectrum Therapy Clinic

Payment Policy

I, _____, parent/guardian of _____,

(print name) (client's name)

elect to use the following funding sources to cover fees incurred at The Learning Spectrum:

Speech Therapy:
☐ Self-Pay
☐ Private Insurance*
☐ Medicaid
☐ Autism Scholarship Program
☐ Delaware County Board of Developmental Disabilities
☐ Other: _____

Occupational Therapy:
☐ Self-Pay
☐ Private Insurance*
☐ Medicaid
☐ Autism Scholarship Program
☐ Delaware County Board of Developmental Disabilities
☐ Other: _____

Music Therapy:
☐ Self-Pay
☐ Autism Scholarship Program
☐ Delaware County Board of Developmental Disabilities
☐ Other: _____

I understand that if the above-named funding sources do not cover the cost of fees incurred, I am responsible for paying the remaining balance. Invoices that are over 60 days past due will be turned over to collections and therapy services will be terminated.

I understand that should I choose to self-pay for services rendered, I am responsible for paying balances in full upon receipt.

If I choose to fund therapy services with my private insurance company, I understand that coverage for services is not guaranteed, and is subject to my policy and coverage. I understand that I am responsible for paying a co-pay or co-insurance, if applicable, and that co-pay is due at the time of service. If not paid at the time of service, the co-pay will be invoiced monthly.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

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NOTICE OF PRIVACY PRACTICES

This Notice is effective July 18, 2011

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

WE ARE REQUIRED BY LAW TO PROTECT HEALTH INFORMATION ABOUT YOU

We are required by law to protect the privacy of health information about you and that identifies you. This health information may be information about health care we provide to you or payment for health care provided to you. It may also be information about your past, present, or future medical condition.

We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to health information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for all protected health information that we maintain. If we make changes to the Notice, we will:

- Post the new Notice in our waiting area.
- Have copies of the new Notice available upon request (you may always contact our Privacy Officer at 614-844-5433 to obtain a copy of the current Notice).

The rest of this Notice will:

- Discuss how we may use and disclose protected health information (PHI) about you.
- Explain your rights with respect to PHI about you.
- Describe how and where you may file a privacy-related complaint.

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact our Privacy Officer at 614-844-5433

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

We use and disclose health information about patients every day. This section of our Notice explains in some detail how we may use and disclose PHI about you in order to provide health care, obtain payment for that health care, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose protected health information about you. For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, contact our Privacy Officer at 614-844-5433.

1. Treatment

We may use and disclose PHI about you to provide health care treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others.

2. Payment

We may use and disclose medical information about you to obtain payment for health care services that you received. This means that, within the health department, we may use PHI about you to arrange for payment (such as preparing bills and managing accounts). We also may disclose PHI about you to others (such as insurers, collection agencies, and consumer reporting agencies).

3. Healthcare Operations

We may use and disclose PHI about you in performing a variety of health care operations to evaluate and improve the quality of services or to write new guidelines to provide more effective care; to conduct supervision of employees or evaluate their performance; to train our employees; to determine satisfaction with our services; for general business planning and development; or for business management and general administrative activities.

4. Persons Involved in Your Care

We may disclose PHI about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. For more information on the privacy of minors' information, contact our Privacy Officer at 614-844-5433.

We may also use or disclose PHI about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose PHI about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we may or may not be able to agree to your request.

5. Required by Law

We will use and disclose PHI about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose PHI. For example, state law requires us to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

6. National Priority Uses and Disclosures

When permitted by law, we may use or disclose medical information about you without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is so important to disclose PHI that it is acceptable to disclose PHI without the individual's permission. We will only disclose PHI about you in the following circumstances when we are permitted to do so by law. Below is a list of the "national priority"

activities recognized by law. For more information on these types of disclosures, contact our Privacy Officer at 614-844-5433.

- Threat to health or safety
- Public health activities
- Abuse, neglect or domestic violence
- Health oversight activities
- Court proceedings
- Law enforcement
- Coroners and medical examiners
- Workers' compensation
- Research organizations (approved by the Privacy Officer)
- Certain government functions such as national security

7. Authorizations

Other than the uses and disclosures described above (#1-6), we will not use or disclose medical information about you without the "authorization" – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

YOU HAVE RIGHTS WITH RESPECT TO MEDICAL INFORMATION ABOUT YOU

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer at 614-844-5433.

1. Right to a Copy of This Notice

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Privacy Officer at 614-844-5433.

2. Right of Access to Inspect and Copy

You have the right to inspect (which means see or review) and receive a copy of medical information about you that we maintain in certain groups of records. If we maintain your medical records in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your medical records. You may also instruct us in writing to send an electronic copy of your medical records to a third party. If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing.

If you would like a copy of the medical information about you, we will charge you a fee to cover the costs of the copy. Our fees for electronic copies of your medical records will be limited to the direct labor costs associated with fulfilling your request.

3. Right to Have Medical Information Amended

You have the right to have us amend (which means correct or supplement) medical information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you would like us to amend information, you must provide us with a request in writing and explain why you would like us to amend the information.

4. Right to an Accounting of Disclosures We Have Made

You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send a written request to the Privacy Officer.

5. Right to Request Restrictions on Uses and Disclosures

You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and health care operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

- Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of health care operations (and is not for purposes of carrying out treatment); and,
- The medical information pertains solely to a health care item or service for which the health care provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

6. Right to Request an Alternative Method of Contact

You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address. You must submit a written request to the Privacy Officer.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint either with us or with the federal government.

We will not take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

125 Dillmont Drive
Columbus, OH 43235

125 Dillmont Drive, Columbus, Ohio 43235
Phone: 614-844-5433 Fax: 614-987-8643
Email: therapy@thelearningspectrum.com

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, parent/legal guardian of _____,
(print name) (client's name)

acknowledge that I have been notified of the privacy practices set forth in the Notice of Privacy Practices.

Parent/Guardian Signature: _____ Date: _____

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Release of Records Form

INTERAGENCY RELEASE OF INFORMATION

By signing and dating this release of information, I allow the persons or agencies listed below to receive and share specific information, as checked, about my case, with The Learning Spectrum, Ltd. I understand that this is a cooperative effort by agencies involved to share information that will lead to better utilization of community resources and better cooperation amongst our agencies to best meet my needs.

Agencies or agency representatives that are permitted to share information with and/or receive information with The Learning Spectrum, Ltd.:

Name/Agency	Phone #	Address	Email	Fax #
Ex: child's home school district, outside therapy provider, county coordinator				

The information to be released is:

☐ Evaluation Reports ☐ Prescriptions ☐ Psychological Assessments
☐ Progress Summaries ☐ Diagnosis ☐ Medication Information
☐ Legal issues/concerns ☐ Performance ☐ School Evaluations
☐ Other (specify): _____.

For the purpose of: _____.

This consent to release is valid while receiving services at The Learning Spectrum, or until otherwise specified, and thereafter is invalid. Specify date, event, or condition on which permission will expire:

_____

I understand that at any time between the time of signing and the expiration date listed above I have the right to revoke this consent.

Client Name: _____ Date of Birth: _____

_____ _____ _____
Guardian or Responsible Party Signature Relationship to Client Date

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COVID-19 DISCLAIMER & CONDITIONS OF ENTRY

To ensure your safety and the safety of our staff and students, TLS Staff are doing everything that we can to reduce exposure and the risks of transmission of Coronavirus.

While on TLS property, we ask that everyone maintain social distancing guidelines, visitors and staff wear a mask that covers the nose and mouth at all times, and utilize hand sanitizing stations. If you feel sick, or have been exposed, please avoid visiting our TLS locations.

TLS cannot guarantee that visitors, students or staff may not be exposed to, and is NOT RESPONSIBLE for the transmission of COVID-19 to any visitor on TLS property.

TLS Conditions of Entry process applies to every visitor to every TLS property. *Visitors include ANYONE not considered staff or enrolled student/client. All visitors will need to follow the building check-in process before entering. This check-in process will consist of the following:

Checking of temperature: If your temperature is equal to or higher than 100 °f we will be unable to allow you entry. Your temperature will be noted and you will be allowed re-entry after 48 hours fever free without the use of fever reducing medications.

COVID-19 Checklist: You will be asked a series of questions before entry is allowed.

*TLS reserves the right to deny entry to any individual, with or without these symptoms and/or require a doctor's note for clearance.

***TLS reserves the right to deny entry to any individual or remove any individual from TLS property who fails to comply with our rules and regulations regarding COVID-19 and the safety of our staff and students.

By signing below, you acknowledge that you have received, read and understand the above information.

Signature: _____ Date: _____

Printed Name: _____