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www.sensorykidsot.com

CLIENT AGREEMENT

Welcome to Sensory KIDS! We are looking forward to working with you and your family! Please review the following policies to better understand our therapy process. At the end of each section, please indicate your agreement to abide by these policies by initialing or signing where indicated. Any questions regarding the information included in this agreement can be directed to our front office at 503-575-9402 or by direct email to info@sensorykidsot.com. Thank you!

Included in this Client Agreement are the following:

1. Financial Policy
2. Cancellation Policy
3. Scheduling and Consultation Policy
4. Communication Notice
5. Office Etiquette and Acknowledgement of Risk
6. Teaching Activities
7. Photograph and Video Release

If you would like to request a copy of your signed Client Agreement for your records, please initial below and our office will provide you a copy upon receival.

Initials: _________

Send to (notate email or mailing address):___________________________________

FINANCIAL POLICY

BILLING, COPAYMENTS, OUT-OF-POCKET EXPENSES, AND VISIT TRACKING

BILLING AND BALANCES

1. **Payments including co-payment, private pay dues, and other out-of-pocket expenses are collected at the time of service.** We accept payment by cash, check, VISA, MasterCard, American Express, and Discover Card. Families are financially responsible for all charges whether or not services are covered and paid by insurance.

2. Insurance is pre-verified. **If Sensory KIDS is contracted with your insurance provider**, we will bill your provider on your behalf. **IN NETWORK** deductible and co-insurance amounts will be billed to you after claims have processed through insurance. Our billing team, MBA Medical Billing, sends out statements on the first of each month. Please be aware that some services provided may be non-covered services and/or not considered reasonable and necessary under Medicaid, as well as other medical insurance companies. If for any reason a portion of a bill or service is not paid by insurance as expected, you are responsible for prompt payment of the remaining charges.

   If Sensory KIDS is not contracted with your insurance provider, payment will be collected at the time of service until the individual or family **OUT OF NETWORK** deductible has been reached (whichever comes first). Sensory KIDS, LLC and MBA Medical Billing will track all payments toward your out of network deductible limit. If you are due a refund at any point, as a result of co-insurance kicking in or an abrupt change in coverage, you will be issued one promptly. Once the out of network deductible has been met, MBA will begin to bill your family on the first of each month for co-insurance charges. The following charges will be applied to your out of network deductible until it has been met:

   - **$165 per OT session**
   - **$165 per parent meeting**

3. **Evaluations** will be billed to insurance. It is your sole responsibility to financially cover payment for the evaluation service if an evaluation has already been rendered at another facility and submitted to insurance for payment within a given period of time. Insurance will only cover one evaluation per set number of days.

4. Families can set up a payment plan at any point in therapy, if this is more of a financially feasible option.

5. We request prompt payment on all statements sent by MBA Medical Billing. **Balances after insurance reimbursement are due within 30 days of the statement date**, unless other payment arrangements have been made with Sensory KIDS.

6. **Outstanding Bills:** Sensory KIDS reserves the right to request payment for any outstanding balances. All outstanding balances greater than 45 days past due will result in treatment termination. In order for treatment to be reinstated, the due balance must be paid in full or a payment plan agreement must be signed. All outstanding balances 120 days past due will be sent to a collection agency.

   - **FOR MEDICAID MEMBERS ONLY:** Medicaid members cannot be balance billed on unpaid claims, however Sensory KIDS reserves the right to terminate treatment due to any issues related to unpaid claims. Medicaid members can be billed out-of-pocket expenses related to no-show or late cancellation fees, per this signed client agreement**.** All Medicaid members are required to maintain active Medicaid status throughout therapy.

7. Personal checks that do not clear due to insufficient funds shall be resubmitted to Sensory KIDS, along with payment for any charges associated with the bounced check.

8. Private Pay families may request a payment plan agreement at any point during their child's therapy. Payment plans for Private Pay families are maintained by Sensory KIDS and not MBA Medical Billing. Private pay dues are collected at the time of service.

INSURANCE

Sensory KIDS is in-network with the following insurance companies: Aetna, Moda Health, TriCare, Cigna, OHP/Care Oregon, Health Share OHSU and Regence BCBS. Sensory KIDS is able to bill as an out-of-network provider to United Health Care, Providence, and Pacific Source. If your family has an insurance plan that we do not bill for, Sensory KIDS will provide a superbill at your request to submit to insurance on your own.

As a courtesy to our families, Sensory KIDS provides a verification of insurance benefits and eligibility before services are rendered. This information is **not a guarantee of payment** and all services are subject to the terms and agreement of your

insurance plan. Your insurance is a contract between you, your employer, and your insurance company. As such, Sensory KIDS is not a part of this contract and bills insurance as a courtesy. It is the responsibility of your family to clarify the terms and conditions of your insurance plan. Accurate information on covered services is only available once a claim has been made.

1. Should your insurance coverage change, it is your responsibility to notify our office within **30 days** of the effective date. A new copy of insurance cards must be provided. Following the 30 days, if no new insurance information is received, Sensory KIDS will no longer bill on your family's behalf, and all future claims and/or charges will be patient responsibility.

2. Sensory KIDS will obtain any prior authorizations required by your insurance plan. If a PCP referral is required, it is your family's responsibility to obtain one before services can be rendered. **All OHP plans MUST have a PCP referral on file for insurance requirements before treatment can begin.**

3. Sensory KIDS will assist with tracking visits; however, it is your responsibility to track used visits in accordance with the number of visits allowed and/or approved by your insurance plan. The number of visits approved by your insurance plan is NOT related to the recommendation of our therapists. If therapy exceeds the number of allowable and/or authorized visits, you will be responsible for any out-of-pocket expenses. It is important to understand hard limits to the number of visits allowed by your insurance plan. Sensory KIDS may request additional visits on your family's behalf based upon the recommendations of the therapist and the limitations of your plan, but we cannot guarantee that additional visits will be approved.

4. If at any point in your child's therapy, insurance no longer covers a service due to a lack of medical necessity, our office will appeal on your family's behalf at your request (when applicable). However, it is your responsibility to pay for any uncovered charges. We do not accept responsibility for paying or negotiating any settlements on unpaid claims, especially in the case of an appeal denial.

Sensory KIDS understands that financial problems may unexpectedly arise and affect payment on your family's account. If this is the case, we urge families to contact Sensory KIDS or MBA Medical Billing for assistance in managing their accounts. Families can contact our office at any point to establish a payment plan.

CREDIT OR DEBIT CARD

For your convenience, your family has the option of placing a card on file for automatic payments related to copays, deductible, private pay dues, or co-insurance charges. If your family would like to keep a card on file, please provide the appropriate information below. Please note, that if your family does not choose to place a card on file, any payments due at the time of service must be made in person before the treatment session begins.

MasterCard: _______ Visa: _______ Discover: ______ American Express: ______

Card Number: _____________________________________ Expiration: ___________________

CSV Number: ___________

Card Holder Name: __________________________ Card Holder Signature: ____________________________

Billing Address:

____

Street City State Zip

If providing credit or debit card information, please initial the following:

1. _____ I understand Sensory KIDS, LLC will charge my card automatically for any co-payments and/or private pay fees related to my deductible or out-of-pocket responsibility at the time of service.

2. _____ I would like Sensory KIDS, LLC to charge my card automatically on the first of each month regarding any due balances on my account.

3. _____ I would like Sensory KIDS, LLC to send me a copy of my purchasing receipt via email for each transaction run on my card.

If a credit or debit card was NOT provided, please initial the following:

1. _____ I understand that all private pay and/or out of pocket expenses must be paid in-person, at the time of service.

2. _____ I understand that if my out of network deductible has not been met, I will be responsible for the following charges at the time of service:
   - $165 per OT session
   - $165 per Parent Meeting

Please initial the following statements:

__________ I give Sensory KIDS, LLC and MBA Medical Billing permission to bill my insurance provider directly, if applicable.

__________ I understand that copayments, private pay fees, out-of-pocket expenses, and fees related to my out of network deductible are due at the time of service.

__________ I understand that I can request a payment plan with Sensory KIDS and MBA Medical Billing at any point while receiving services.

__________ I understand that in network deductible and co-insurance amounts will be billed to me on the first of each month by MBA Medical Billing. I understand that Sensory KIDS has the right to request payment for outstanding balances. I understand that if I have an outstanding balance greater than 45 days, my child's treatment will be terminated until payment has been made. I understand that outstanding balances 120 days past due will be sent to a collection agency.

__________ I have confirmed with my insurance provider the information provided to me in the verification document originally sent by Sensory KIDS, including my plan's coverage limitations, co-pays, and co-insurance. If I am paying privately, or for any out-of-pocket expenses, Sensory KIDS has reviewed with me the details of their service costs and I understand my financial responsibility in making payments at the time of service.

__________ I understand that if my insurance is OHP, I must obtain a PCP referral for Sensory KIDS, LLC before treatment begins. I understand that a PCP referral is required by OHP for insurance and authorization purposes.

__________ I understand that Sensory KIDS, LLC only assists in the tracking of visits and it is my responsibility to track my child's visits. I understand that if for any reason therapy exceeds the number of allowable and/or authorized visits, I will be responsible for any out-of-pocket expenses.

__________ I have read the above information and understand that, as a client, parent or guardian, I am ultimately responsible for payment of all services provided by Sensory KIDS, LLC. In the event that my insurance company refuses payment for services for any reason, or if any other source of payment falls through, I will be responsible for all past, current, and future service charges.

I hereby understand the financial policy of Sensory KIDS, LLC and agree to abide by it.

________________________________ ________________________________

Parent/Legal Guardian Signature **Date**

CANCELLATION POLICY

LATE CANCELLATION, NO SHOWS, AND ASSOCIATED FEES

Sensory KIDS is committed to providing exceptional care and support to the children and families we serve. Our therapists are dedicated to using best-practice and evidence-based methods to help your child reach goals and feel successful. That means putting time and effort into planning each individual session Please respect our dedication by committing to scheduled appointment times and the agreed-upon treatment plan. **In order to ensure the most effective use of your child's therapy time, we ask that you carefully review and initial the statements below.**

PLEASE NOTE: Insurance companies DO NOT REIMBURSE for any of the fees listed in this policy.
All fees in this Cancellation Policy are parent/guardian responsibility

General Policy Statement: Sensory KIDS, LLC recommends an intensive approach to therapy, however, we understand that not all of our families can accommodate this in their busy schedules. Following the first parent meeting with your therapist, an ongoing treatment schedule will be established based upon the availability of both the therapist and your family. Any changes to your child's ongoing treatment schedule should be requested to our front staff, not the therapist. Sensory KIDS cannot guarantee that your schedule request will be met, however, we will do our best to accommodate. We understand that abrupt endings to therapy may occur in the face of difficult financial situations or life events, but we do ask that families provide at least a 48-hour notice prior to their child ending, so the therapist may prepare the next session for a transition out of therapy.

Appointment Reminders: Our scheduling system, Clinic Source, will send families a reminder email 48 hours before their child's appointment. Families may choose to cancel or confirm their child's session via this reminder email. However, Sensory KIDS asks that families follow-up by phone or email if their child's session needs to be cancelled.

Inclement Weather Policy: The clinic is open except in cases of severe conditions requiring businesses to close. It is the responsibility of our families to call the clinic to determine whether changes in the scheduled time of treatment are needed, and if the opening of the clinic is delayed. Families may cancel treatment if they do not wish to travel because of inclement weather, however, if the clinic is open, a $50 late cancellation fee will be charged for missed appointments that were not given at least 24-hours'notice.

Please initial the following statements:

__________ I understand that it is my responsibility to communicate any schedule changes or requests to the front desk, not my child's therapist.

__________ I understand that my child shall always be accompanied by a guardian at the start and end of each therapy session (unless your child is 16 years or older). I understand that drop-offs are allowed when planned with the front staff and my child's therapist, but cannot become a common occurrence.

__________ Parents/Guardians who arrive later than 15 minutes into their child's appointment time will be charged a **$50 late cancellation fee**, and will result in the child's appointment being cancelled for that day. Appointments cannot be extended, as they are scheduled back-to-back. Therapy is not effective if not given the full amount of time. We ask that you respect the therapist's time, as well as your own, and allow your family plenty of time to make it to your appointment.

__________ If an appointment is cancelled with less than 24-hours' notice, except in the case of illness, the appointment will count as a late cancellation and you will be charged a **$50 late cancellation fee**. I understand that 3 cancelled appointments in a row will result in the termination of my child's scheduled treatment times. Exceptions to this are previously planned absences made with our front office at least 1 week prior to the cancelled dates.

__________ Treatment sessions are 50 minutes long, but are scheduled for 1 hour. Parents/Guardians are expected to show at the 50-minute mark to assist with the transition out of therapy and check in with the therapist. I

understand that if I do not show at the 50-minute mark, a **$25 late pick-up fee** will be charged to my account for every 10 minutes over my child's therapy time.

___________ I understand that if I fail to show up to my child's appointment with no notice, I will be charged an **$88 no-show fee**. I understand that 3 no-shows will result in the termination of my child's scheduled treatment times.

___________ If your child is sick with a temperature over 100 degrees, a cough, or has vomited in the last 24 hours, please immediately call our office to cancel your child's appointment. Cancellations due to illness will not be charged a cancellation fee.

___________ **Feeding sessions** require a significant amount of money and time for planning and preparations. I understand that if my child is doing feeding therapy, I will be charged a **one-time fee of $50** that will cover food costs for all of my child's feeding sessions. Additionally, if I need to cancel my child's feeding session, I understand that I need to give 48-hours' notice, except in the case of illness.

___________ I give Sensory KIDS, LLC permission to send reminder emails via their Clinic Source scheduling system to the email address I originally provided.

___________ I have read and understand the Inclement Weather Policy.

Sensory KIDS is happy to work with families when there are scheduling issues. If problems arise with your child's ongoing treatment schedule, please inform our front office staff. Sensory KIDS is able to hold therapy spots for up to two weeks. If your child is pulled off the schedule for any reason, we will do our best to fit your child back in as soon as possible.

I hereby understand the cancellation policy of Sensory KIDS, LLC and agree to abide by it.

____ ________________________

Parent/Legal Guardian Signature **Date**

SCHEDULING AND CONSULTATION POLICY

END DATES, PARENT MEETINGS, LEGAL/PROFESSIONAL CONSULTATION

General Scheduling Statements: Treatment sessions run 50 minutes long, but are scheduled for 1 hour. The last 10 minutes of a child's session is utilized for transitions out of therapy, parent check-ins, and therapist notes. Treatment sessions are scheduled back-to-back, and as a result, treatment time cannot be extended.

Following the initial evaluation, Sensory KIDS recommends a round of 30 treatment sessions and 3 parent education meetings. Treatment sessions will be scheduled based upon the availability of the therapist and your family. Parent education meetings run 50-minutes long, are ADULT ONLY, and will be scheduled as follows:

- **1st Meeting:** Scheduled after the evaluation to review evaluation results, discuss a treatment plan, and establish goals. Following this, your child's treatment will be scheduled.
- **2nd Meeting:** Scheduled mid-way through your child's treatment to review goals, strategize on a home plan, and discuss progress.
  - Around this time, a HARD END DATE will be established with your family when the therapist recommends a break after 30 sessions (or the number of allowed visits by your insurance plan). Hard end dates are not adjusted in the case of cancellations, therapist absences, or office closures. Hard dates can be re-evaluated at any point by the therapist or at the request of the family.
- **3rd Meeting:** Scheduled at the end of your child's treatment to discuss the transition out of therapy and finalize home strategies/supports.

*All families who plan to return to Sensory KIDS after taking a break will be placed on the therapist's priority list with a projected return date. Our office will reach out to your family close to this projected return date in an effort to establish a new treatment schedule.

Parent Commitment: We believe strongly that parent involvement is the key to success in therapy. While therapists may require some one-on-one time to develop a strong relationship with your child, we encourage parents to be involved in the process by observing or participating in your child's treatment sessions.

Please initial the following:

__________ If it is necessary for my child's siblings to accompany me to the treatment sessions, I understand that I am expected to stay with them in the waiting area or in one of the observation rooms. I understand that siblings can only participate in my child's treatment session when previously planned or requested by the therapist.

__________ I understand that treatment sessions run 50 minutes long, and that any payments or scheduling needs should be taken care of at the beginning of my child's session. Additionally, I will support my child and my child's therapist with the transition out of session by showing up at the 50-minute mark.

__________ I understand that longer conversations about my child's therapy will be saved for designated parent education meetings or email. I understand that I may request a parent meeting or phone consultation at any point in my child's therapy, and will be responsible for all service charges related to my request.

__________ I understand that parent education meetings are **adult-only**. I understand that children are not allowed in parent education sessions and cannot be left unsupervised during these sessions.

__________ I understand that my child will receive a hard end date mid-way through their treatment based upon the recommendation of the therapist (when applicable). I understand that this hard end date is established for scheduling purposes and cannot be adjusted in the case of cancellations, therapist absences, and office closures.

__________ I understand that cell phones are disruptive and are not to be used in the clinic during sessions, especially in the waiting area. If observation rooms are open, families may take any necessary calls in these rooms with the door closed upon notifying front staff. All other calls should be taken outside the clinic.

Communication: Discussions about your child are not appropriate to have with your child present. We offer families the opportunity to schedule a 15-minute complimentary phone consult when a short consultation is sufficient. Additionally, families may request an adult-only parent meeting with the therapist at any time.

Legal Consultation: Any fees associated with legal counsel or court appearances will be billed to the family's lawyer, or the family directly, at the out-of-pocket rate of $165/hour. This fee is NOT COVERED by insurance. All requests for legal counsel should be directed to Sensory KIDS front staff for scheduling purposes. Therapists are not obligated to discuss legal matters over email.

Professional Consultation: Therapists at Sensory KIDS are willing to work closely with any professionals related to your child's care. Information can be shared once a Release of Information Form has been filled out appropriately and returned to our front staff. **Consultations with related medical professionals will be billed to insurance when applicable**. Private pay families will be billed for professional consultations in 15-mintue increments at the hourly therapy rate. Therapists are not obligated to discuss your child's therapy with related medical professionals over email.

Emails: Email communication should be used for quick updates regarding your child's therapy. Email communication taking over 10 minutes will be billed in 15-minute increments at the hourly therapy rate to your family. This fee is NOT COVERED by insurance.

Please initial the following:

__________ I understand that any fees associated with legal consultation will be billed to my lawyer or directly to my family. I understand that all requests for legal consultation will be directed to the front staff.

__________ I understand that professional consultations require a signed Release of Information form, and that all requests should be made directly to the front staff. I understand that I will be responsible for any charges associated with my request.

__________ I understand that I will be responsible for any charges associated with lengthy email communication.

I hereby understand the scheduling and consultation policy of Sensory KIDS, LLC and agree to abide by it.

____ _________________________

Parent/Legal Guardian Signature **Date**

COMMUNICATION NOTICE

At Sensory KIDS, we handle most of our communication to families through our main email account: info@sensorykidsot.com. This email is HIPAA protected, making it safe to discuss your child's therapy and to send any documentation related to your child's therapy. The following will be handled by email, unless otherwise requested by phone:

- Initial intake
- Scheduling the initial evaluation, any parent meetings, as well as treatment sessions
- Appointment reminders through Clinic Source
- Notices of therapist absences
- Notices of office closures
- Cancellation and rescheduling of treatment sessions
- Schedule requests and/or changes
- Insurance related inquiries or issues
- Payment questions and receipt sending
- Sensory KIDS Monthly Support Group emails
- End of treatment surveys
- Recruitment for research projects

Please initial the following:

__________ I understand that Sensory KIDS' main communication is done through email.

__________ I give Sensory KIDS permission to email me for anything associated with my child's therapy. If there is something that I would like Sensory KIDS to directly contact me by phone for, it would be (put n/a if not applicable): ____

____

I hereby understand Sensory KIDS, LLC's communication notice.

____ _________________________

Parent/Legal Guardian Signature **Date**

OFFICE ETTIQUETTE AND ACKNOWLEDGEMENT OF RISK

ETTIQUETTE, SAFETY, DISCHARGE

Sensory KIDS, provides support for all kids and families without regard to race, color, religion, sex, disability, gender identity, sexual orientation, or age. We hope to provide a place of comfort and safety to our families, in addition to an atmosphere that is positive, fun, and inviting. So Sensory KIDS can make a comfortable and safe space for all, we ask the families respect the following:

1. Closely monitor your child's behavior in the waiting room to ensure playing is safe and appropriate for other children in the room. Children are prohibited from climbing walls and/or jumping from any surfaces or office furniture. Office toys, books, or crafts should be handled with care under the supervision of a parent/guardian.
2. Please clean up after your children in the waiting room. We ask that all books and toys are put back where they were found. Trash and recycle can be found in the waiting room under the front desk.
3. All children should be accompanied by a parent or guardian when going to the restroom. Any families with children who require diapers or pull-ups should bring a diaper bag to therapy and be prepared to change your child if necessary.
4. Children are NOT allowed in the treatment area unless accompanied by the therapist.
5. Before entering treatment areas, we ask that shoes be removed and placed by the front door. Any coats/jackets can be placed on the available wall hooks.
6. No outside food should be taken beyond the waiting room, with the exception of food therapy sessions. Please clean up any food messes that occur, and notify the front staff immediately if further assistance with cleaning is required.
7. Families are always invited to participate in the child's session, however siblings are not allowed in the treatment areas unless otherwise planned with or requested by the therapist.
8. Please refrain from cell phone conversations in the waiting area. Please keep tablet use to a minimum, ensuring the volume is on silent. Necessary phone conversations can be carried out in an available observation room or outside the clinic.
9. In compliance with HIPAA, front staff and therapists are unable to discuss any other families/clients who may be receiving therapy at the clinic. Please be mindful of the content discussed with your family members, as well as the therapist.

Acknowledgement of Risk: There is some risk inherent in the use of therapy equipment at Sensory KIDS. By signing below, you agree to indemnify and hold Sensory KIDS, LLC harmless from any and all losses and claims for injuries or damages that may occur to you, your family, and your belongings from the use of our therapeutic equipment. Siblings are not allowed into treatment spaces unless otherwise requested and supervised by your child's therapist, as this poses a risk to safety for children and liability for Sensory KIDS, LLC.

Discharge: It is the policy of Sensory KIDS to discharge clients when they have met the following criteria:

- **Sufficient Progress** – When a child has demonstrated sufficient progress, the therapist will review the child's progress with the family and recommend a break. A hard end date will be established mid-way through the child's treatment for families whose therapist has recommended a break.
- **Financial Responsibility** – If a family is not accepting financial responsibility as outlined in our financial policy, the child's therapy may be terminated.
- **Attendance** – If three consecutive sessions are cancelled or marked as no-shows, the child's therapy will be immediately terminated.
- **Family Request** – Discharge of a child can be requested by the child's family. We ask that families provide 48-hours' notice if they know their child will be ending therapy.
- **Agency Discretion** – Sensory KIDS reserves the right to discharge any client at any time for any reason

Please initial the following:

__________ I have read and understand the Discharge Policy. I understand the Sensory KIDS reserves the right to discharge any client at any time for any reason.

I hereby understand and will adhere to the office etiquette and acknowledgement of risk as outlined by Sensory KIDS, LLC.

____ ________________________

Parent/Legal Guardian Signature **Date**

TEACHING ACTIVITIES

INTERNS AND VOLUNTEERS

Sensory KIDS is a teaching facility that values learning and education. Master and doctorate level students studying occupational therapy complete internships at our facility, and therefore, will frequently observe and take part in therapy sessions, with the therapist giving notice. Additionally, volunteers are frequently onsite to support therapists and administrative staff, and may observe sessions as deemed appropriate by the therapist. Both intern students and volunteers adhere to our clinic policies and federal privacy guidelines.

Please initial the following:

__________ I give permission for occupational therapy students to participate in my child's therapy session.

__________ I understand that volunteers may observe my child's session, as deemed appropriate by my child's therapist.

__________ I understand that my child may be photographed or videotaped for educational purposes. I understand that any such records or photographs will be reviewed by me prior to any release.

I hereby understand and agree to the teaching and research activities outlined by Sensory KIDS, LLC.

______________________________________ ______________________

Parent/Legal Guardian Signature **Date**

PHOTOGRAPH AND VIDEO RELEASE

In compliance with federal and state regulations your permission is sought to allow your son/daughter/self to appear in photographs and/or videos recorded in our clinic. Children and adults involved in recording will not be identified in any manner.

Please initial each individual condition and sign below to express permission for photographs, videos, and their use:

______ Photo for Medical Software System.

______ Photos and video recordings may be used for review by our therapists.

______ Photos and video recordings may be used for educational purposes.

______ Photos and video recordings may be used for marketing purposes.

Please sign below:

For adults18 years of age or older

Signature: ____ Date: __________

Printed Name: ____

For children under 18, please provide parent or guardian signature:

Child's Name: ____

Parent/Guardian Signature: ____ Date: ___________

Printed Name: ____