IntraCare

Terms and Conditions

Personal property

You understand and agree that IntraCare is not and will not be responsible for the loss of, or damage to, any personal property (including jewellery, dentures, watches, rings, glasses) which you may bring.

Payment terms

- The price shall be as indicated on the invoice(s) provided by IntraCare to you in respect of the Services supplied. Unless otherwise stated, all prices include GST.
- For insurance funded procedures, IntraCare requires a copy of the prior approval letter. If we do not receive the prior approval letter at least one business day prior to your admission, you will need to pay for the procedure and claim this back from your insurer.
- IntraCare is affiliated with Southern Cross and AIA, IntraCare can claim the cost of some procedures from these affiliated providers. If you are unsure whether your procedure is covered, please contact our administration team on (09) 630 1961.
- If you are not fully insured and/or have an excess or co-payment, you will need to pay the portion not covered by insurance and/or the excess, at least one business day prior to your admission. If payment is not received within this time frame, your procedure booking date may be rescheduled. Please contact our administration team to arrange payment.
- Any amounts due to IntraCare relating to your procedure either from you, your insurance provider or other party remains your full responsibility, however arising, including overdue payment, nonpayment, outstanding part-payment or if your insurance provider or other party subsequently declines cover or part cover.
- If you have an outstanding balance due to IntraCare, you agree to indemnify IntraCare from and against all costs and disbursements incurred by IntraCare in recovering the debt (including but not limited to internal administration fees, legal costs, IntraCare's collection agency costs and bank dishonour fees).
- The actual cost of the procedure may vary to the estimate. If you are not fully insured and/ or have an excess or portion to pay, you may be invoiced for an additional amount if the actual cost of your procedure is higher than the estimate. This is payable upon invoice. If the cost of the procedure is lower than the estimate, you may be eligible for a refund for any overpayment. Refunds are typically paid within 7 business days.

Please provide your bank account name and bank account number so that refunds can be processed promptly.

Bank account name: _____

Bank account number: _____

Privacy and financial interests disclosure statement

For the purposes of this Privacy and Financial Interests Disclosure Statement, "IntraCare" is an agency, and means:

1. The Company, Intra Limited, employees including technical staff, nursing staff and administrative staff; and.
2. Medical Specialists credentialed to work with IntraCare.

IntraCare understands the privacy of your personal and health information is important to you. In this Statement we use the term "Personal Information" to include both personal and health information, and we explain how we meet our obligations under the Privacy Act 2020; Health Information Privacy Code 2020 and other relevant legislation when we collect, use and share your Personal Information.

Collection of your Personal Information:

IntraCare usually collects Personal Information directly from you. We also collect information about you from the doctor or agency that referred you to IntraCare. Where necessary to ensure we can provide you with safe and effective services we may also collect Personal Information about you from other persons such as your General Practitioner, specialist, any other health professional who has treated you for a relevant condition, your family or whānau with your consent, or other sources if you consent or we are authorised by law.

Purposes for which we use your Personal Information:

We collect and use information about you to ensure we can provide high quality, safe and effective services to you. This may include, but is not limited to: the provision of medical care and advice; making appropriate referrals to other health professionals; monitoring the quality of, and improving, our services; providing relevant training to our staff and health professionals providing services at IntraCare; responding to enquiries, concerns or complaints; and for matters related to the administration of those services including charging, billing, and debt collection. We also securely share limited personal data with Cemplicity for the sole purpose of facilitating a patient feedback survey invitation to you. The data shared with Cemplicity will not be held longer than the purpose of conducting the patient's survey i.e. 21 days. All data stored by Cemplicity is to ISO 27001 standard and in accordance with the Privacy Act 2020.

Intended recipients and disclosure of your Personal Information:

When you receive treatment or procedures at IntraCare, a report is provided to your referring health professional. We may also disclose relevant Personal Information connected to the provision of your medical care and/or the services provided to you by IntraCare, to: your General Practitioner; other health professionals or health service providers involved in your treatment or diagnostic services or where we make referrals on your behalf; or to Health New Zealand and/or ACC where relevant. We provide relevant information to Testsafe, a secure electronic database provided by Health New Zealand. This enables health providers who are involved in providing care to you to access relevant clinical information to improve services to you. Only authorised health providers have access to this system. We may also disclose relevant Personal Information about you where it is necessary to submit health insurance claims on your behalf; for quality assurance, audit and accreditation issues; where information is required for the provision of emergency medical care; or where the disclosure is otherwise authorised or required by law.

We may also convey relevant Personal Information to a responsible person (e.g. a guardian, parent, spouse/partner, main caregiver or close family/whānau member) in accordance with recognised professional practice, or if you are incapable or cannot communicate unless you have specifically requested the information is not disclosed in this manner.

Your Personal Information may also be disclosed where necessary for IntraCare to respond to or defend any action or complaint against it, or for research and development purposes with your consent or where only anonymised or de-identified information will be disclosed.

Access and correction of your Personal Information:

You have a right to seek access to and correction of Personal Information we hold about you in accordance with the Privacy Act 2020 and Health Information Privacy Code 2020. To ensure the security of your information, we will ask you to verify your personal details, before we release any information to you.

Possible financial interest in the facility or part of the facility:

The doctor you see may have a financial interest in part of the facility in which you receive treatment or may be referred to, but at all times has a duty to act in your best interests when making referrals and providing or arranging treatment or care. If you have any questions about this please ask the doctor concerned.

IntraCare is the agency collecting your Personal Information and holding that information. Our office address is 98 Mountain Rd, Epsom, Auckland. If you have any questions relating to how your personal information is collected, used or may be disclosed please contact our Privacy Officer at: admin@intracare.co.nz or (09) 630 1961.

Providing Personal Information and signing this Statement:

You do not have to provide Personal Information to IntraCare, however not providing Personal Information may impact on our ability to provide you with the services you require. By ticking that you consent, and signing this Privacy and Financial Interests Disclosure Statement, you consent that your Personal Information may be collected, used and disclosed as explained above. If you do not consent to the possible disclosure of your information to a third party outside of IntraCare as set out above, please tick the "do not consent" box, and we will request your consent in relation to any specific disclosure that is proposed, unless the disclosure is authorised or required by law.

☐ I consent to my Personal Information being collected, used and disclosed as explained above;

OR

☐ I consent to my Personal Information being collected and used as explained above but **do not consent** to my Personal Information being disclosed to a third party as explained above without further discussion with me;

AND

☐ I understand that the doctor I see may have a financial interest in part of the facility but is required at all times to act in my best interests. **I have had an opportunity to ask any questions about this and understand I can discuss any concerns I have about this at any time.**

Signature _____

Print name (in full) _____ Date _____

Sample Consent form

Consent for Procedure

IntraCare

Patient Label

Patient name: _____

Date of birth: _____ NHI: _____

Interpreter *(Fill out only if needed)*

◯ **Yes I do** ◯ **No I do not** — want an interpreter

Interpreter name: _____

Language: _____

Planned procedure

_____

_____

Summary of information given

This may include a description of the procedure discussion of risks and benefits, potential complications, alternatives to treatment, decisions that may need to be made during the operation, procedures the patient does **not** want done. Please reference clinic letters and patient information sheets where applicable.

Potential complications include: _____

_____

_____

_____

Staff exposure to blood or body fluids

If a staff member sustains accidental exposure to my blood or body fluids, a blood sample may need to be taken for blood-borne diseases including HIV, Hepatitis B, and Hepatitis C. I consent for the collection of a blood sample in the event of staff injury or exposure. I understand that I will be informed of the results of the blood tests and treatment options if a disease is detected.

Blood or blood products transfusions *(Fill out only if needed)*

Blood or blood product transfusion may be needed during or after the procedure. The reasons for transfusion, the alternatives, and the possible risks have been discussed with me. I have been provided with the **NZ Blood Service Fresh Blood Components** information.

◯ **I agree** to the administration of blood or blood products as considered necessary and medically appropriate, including if my life is in danger. I understand I can withdraw this consent at any time.

◯ **I do not agree** to the administration of blood or blood products under any circumstances, even if my life is in danger. I understand I can alter my decision at any time.

Information received and consent given

- I have had explained to me the nature of my / the patient's condition, the procedure and options for treatment.
- I have been given the opportunity to include my whānau/support persons in my discussions, where this is important to me.
- I have been provided with an assessment of the potential benefits, common or significant side effects and likely outcome of the procedure.
- I have had explained to me situations that may arise during the procedure and possible complications.
- I have had adequate opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.
- I have had the opportunity to state any procedures **I do not** want performed.
- I consent for the collection of a blood sample in the event of a staff "needle stick injury" or other blood accident/exposure.
- I consent to the administration of Section 29 drugs if they are required, and I consent to my personal information being given to Medsafe if Section 29 drugs are administered.

I, or my legal representative, consent to the procedure/s described in this consent form above to be performed on myself:

Patient/Legal representative name: _____ If not patient, state _____

relationship to patient: _____

Signature: _____ Date: _____

Clinician name: _____ Designation: _____

Clinician signature: _____ Date: _____

Legal representative

- "Legal representative" means welfare guardian, enduring power of attorney (care and welfare), or guardian of a child.
- Next of kin does not have legal authority to consent on behalf of an incompetent patient however they may be consulted.

Patient registration form

Allevia Hospitals

My operation/procedure is booked at: ☐ Allevia Hospital Epsom ☐ Allevia Hospital Ascot

Patient details (to be completed by patient)

Title: ... Other: Date of birth:

Legal first name(s):

Family name:

Previous name:

Sex: Is this the same as your birth gender? Yes ☐ No ☐

If 'no', what was your gender at birth? Male ☐ Female ☐

Country of birth: NZ resident: Yes ☐ No ☐ NHI number (if known):

Residential address:

Postal address (if different from above):

Preferred contact number:

Email:

Ethnic group: Language spoken:

Interpreter required: Yes ☐ No ☐ (Interpreter services must be arranged through your specialist's rooms prior to admission)

If visiting from overseas what is your address while staying in New Zealand?

Phone:

Emergency contact person

Name: Preferred contact number:

Relationship to patient:

Health insurer

Name of insurer: Policy type:

Membership number: Prior approval number:

Is your surgery covered by ACC? Yes ☐ No ☐ ACC approval granted: Yes ☐ No ☐

ACC claim number:

GP

Name:

Practice:

Referring medical practitioner (If different from GP)

Name:

Practice:

Specialist

Name: Date of admission: Time of admission:

Prescription cards

☐ High Use Health Card Expiry date:

☐ Prescription Subsidy Card Expiry date:

☐ Community Services Card Expiry date:

☐ Other Expiry date:

ACC claims

Contract claim:

If your medical operation/procedure is an ACC contract claim, ACC will pay the hospital directly for all hospital and specialist's costs excluding personal expenses. Personal expenses, such as visitor meals, will be invoiced directly to patients post-discharge.

Part ACC/part insurance:

Proof of prior approval is required prior or on admission for the portion of your procedure that is covered by insurance. If you are not insured, you will be required to pay a portion of the estimated hospital costs prior or on admission. For further details on ACC reimbursement practices, please ask your ACC case manager.

Payment of hospital costs

For further information please refer to the patient information booklet.

Payment will be made by: ☐ Credit card ☐ Internet banking ☐ EFTPOS ☐ Cash ☐ Other

- If you have no insurance you will be required to pay the full estimated cost of the operation/procedure **on or before admission.**
- If internet banking is done within three days prior to your admission, you will need to provide proof of the transaction prior to admission.
- We strongly recommend you contact our Customer Support team 09 623 6588 (Allevia Hospital Epsom) or 09 520 9575 (Allevia Hospital Ascot) for an estimate of the hospital costs prior to admission.
- If you have prior approval with a private health insurer, you will need to pay any expected shortfall on or before admission.
- You understand and give consent that relevant information may be supplied to an external credit reporting agency to obtain a credit report.
- You agree you are responsible and will pay for all costs incurred in connection with your treatment.
- You understand that Allevia Hospitals may notify a credit reporting agency and/or instruct a debt collection agency should you default on any payment due by you to Allevia Hospitals.
- You understand that any collection and/or legal costs incurred in recovering any debt will be charged to you.

Personal property

You understand and agree that Allevia Hospitals is not and will not be responsible for loss of or damage to any personal property (including jewellery, dentures, watches, rings, glasses) which you may bring into the hospital.

Sharing information

You consent to Allevia Hospitals sharing relevant information that is related to your healthcare and as required by third parties such as health insurers, medical specialists, ACC, and for quality and audit purposes.

To the best of your knowledge the information you have supplied to Allevia Hospitals is correct.

Signature:

Print name (in full):

Date:

Patient health questionnaire

Allevia Hospitals

My operation/procedure is booked at: ☑ Allevia Hospital Epsom ☐ Allevia Hospital Ascot

Dear Patient

The information requested in this form will help us assess your needs and plan your care for your booked admission to Allevia Hospitals. All information will be treated in strict confidence.

When answering the questions, please do not write 'see my notes' or words to the same effect because we will not have all your clinical notes. Please answer as accurately as possible.

Please answer **all questions** on each page even if you think they are irrelevant to your circumstances.

Please bring any relevant X-rays/CT/MRI scans (CD discs) with you along with any mobility aids, CPAP machines etc. to the hospital. If you develop any coughs, colds, infections or wounds before your admission, contact your specialist prior to your admission.

Please ensure you are aware of when you should stop eating and drinking prior to your admission. Your specialist should advise you of these times. Please note this includes chewing gum, lollies, sugar etc. If you do not follow these instructions, you risk having your surgery cancelled.

We look forward to helping you prepare for your operation.

Admissions Unit nurses

Patient details

Legal name: _____ **Date of birth:** (dd/mm/yyyy) _____

Planned procedure: _____

Date of surgery: _____ **Best contact phone number:** _____

Height: _____ cm **Weight:** _____ kg This information is important. **Do not leave this blank.** If you do not know, an estimate is acceptable.

Do you have any allergies? Yes ☐ No ☐

Are you allergic/sensitive to any: (tick which and describe below)

Medications **Foods** **Latex** **Plasters/tape/skin preparations** (e.g. iodine, chlorhexidine) **Other**

Substance	Reaction

Patient health questionnaire
(continued)

Allevia Hospitals

Medications

Do you regularly use any medications? Yes ☐ No ☐ If '**yes**', please provide details in the table below.

Please list **ALL** medicines – tablets, inhalers, patches etc. prescribed by your doctor **or over the counter** (include any herbal or natural remedies). **If you require more space, attach an additional sheet**.

Name of medication	Dose	Frequency

Please bring all your medications, in original packets, with you to hospital.

Do you take any of the below blood thinning medications? Yes ☐ No ☐

☐ Clopidogrel (Plavix) ☐ Warfarin (Marevan or Coumadin) ☐ Dabigatran (Pradaxa) ☐ Rivaroxaban (Xarelto)
☐ Apixaban (Eliquis) ☐ Ticagrelor (Brillinta) ☐ Dipyridamole (Pytazen) ☐ Prasugrel (Effient)
☐ Enoxaparin (Clexane) ☐ None of these

Has your specialist advised you to withhold this medication prior to your surgery? Yes ☐ No ☐

If '**yes**', please provide details:

Have you been taking opioids (i.e. morphine, oxycodone) for a period of more than 3 months? Yes ☐ No ☐

If '**yes**', which medicine/s:

Do you take any medicines to treat opioid dependence (i.e. methadone, Suboxone®), alcohol dependence (i.e. naltrexone) or to aid in smoking cessation or weight loss (i.e. Contrave®, liraglutide, semaglutide)? Yes ☐ No ☐

If '**yes**', which medicine/s:

Have you ever had: ☐ MRSA ☐ ESBL ☐ VRE ☐ CRE ☐ Other multi-resistant organisms
☐ None of these Approximate date:

Have you been a patient or worked in an **overseas** hospital in the last 12 months? Yes ☐ No ☐

If '**yes**', which country: Approximate date:

Have you been a patient for one or more nights in any **New Zealand** hospital in the last 12 months? Yes ☐ No ☐

If '**yes**', when: Hospital/s:

Have you been a resident in a rest home or long-term care facility (e.g. rehab facility) in the last 12 months (excludes independent living in a retirement village)? Yes ☐ No ☐

Have you lived or travelled outside of New Zealand or Australia in the last 12 months? Yes ☐ No ☐

If '**yes**', which countries: Approx. date of return or arrival to New Zealand:

Do you have a history of CJD or other prion disease in your family (including 1st & 2nd degree relatives)? Yes ☐ No ☐

If '**yes**', please provide details:

Have you received human growth hormone or gonadotropin treatment prior to 1986? Yes ☐ No ☐

If '**yes**', please provide details: Date:

Have you received a dura mater graft before 1990? Yes ☐ No ☐

If '**yes**', please provide details: Date:

Have you ever had previous surgery? Yes ☐ No ☐

Patient health questionnaire
(continued)

Allevia Hospitals

Please list **all** previous admissions to hospital for surgical procedures. Please include where and when (estimate if unsure).
If you require more space, attach an additional sheet.

Previous surgery	Hospital	Year

Have you suffered post-op nausea and vomiting with recent surgeries? Yes ☐ No ☐

If '**yes**', please provide details:

Have you or a blood relative ever had any problems during or after anaesthesia?
e.g. malignant hyperthermia, muscular dystrophy Yes ☐ No ☐

If '**yes**', please provide details:

Problems opening your mouth? Yes ☐ No ☐

If '**yes**', please provide details:

Are you or could you be pregnant? Yes ☐ No ☐

If '**yes**', please provide details:

Do you have, or have you ever had, any of the following?

High blood pressure controlled with medication: Yes ☐ No ☐

If '**yes**', please provide details:

Heart attack: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Heart murmur: Yes ☐ No ☐

If '**yes**', please provide details:

Artificial heart valve: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Chest pains/angina: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Coronary angiogram or stents in the heart: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Rheumatic fever: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Atrial fibrillation/palpitations/arrhythmias: Yes ☐ No ☐

If '**yes**', please provide details:

Cardiac devices e.g. pacemaker, ICD: Yes ☐ No ☐

If '**yes**', please provide details:

Have you seen a heart specialist doctor/s in the last 5 years: Yes ☐ No ☐

If '**yes**', please specify: When did you last see them:

COPD/emphysema: Yes ☐ No ☐

If '**yes**', please provide details:

Asthma: Yes ☐ No ☐

If '**yes**', please provide details:

Patient health questionnaire
(continued)

Allevia Hospitals

Persistent cough: Yes ☐ No ☐
If '**yes**', please provide details:

Shortness of breath: Yes ☐ No ☐
If '**yes**', please provide details:

Obstructive sleep apnoea: Yes ☐ No ☐
If '**yes**', do you use a CPAP or other sleep apnoea device? Yes ☐ No ☐

Have you had a 'headcold', throat/chest infection or bronchitis in the 4 weeks prior to admission? Yes ☐ No ☐
If '**yes**', please provide details: Date:

Stroke/TIA: Yes ☐ No ☐
If '**yes**', please provide details: Date:

Anaemia: Yes ☐ No ☐
If '**yes**', please provide details:

Bleeding disorders: Yes ☐ No ☐
If '**yes**', please provide details:

Blood clots in legs or lungs (DVT/Pulmonary embolism): Yes ☐ No ☐
If '**yes**', please provide details: Date:

Epilepsy/seizures: Yes ☐ No ☐
If '**yes**', please provide details: Last seizure date:

Blackouts/fainting: Yes ☐ No ☐
If '**yes**', please provide details: Date:

Diabetes: Yes ☐ No ☐

☐ Type 1 ☐ Type 2

If '**yes**', do you take any of the following medications?

☐ Insulin ☐ Empagliflozin (Jardiance) ☐ Empagliflozin + Metformin (Jardiamet) ☐ Dapagliflozin (Forxiga)
☐ Canagliflozin (Invokana) ☐ Dapagliflozin + Metformin (Xigduo XR) ☐ None of these

Has your specialist advised you to withhold this medication prior to your surgery? Yes ☐ No ☐
If '**yes**', please provide details:

Kidney problems: Yes ☐ No ☐
If '**yes**', please provide details:

Hepatitis: Yes ☐ No ☐
If '**yes**', please provide details:

Liver cirrhosis: Yes ☐ No ☐
If '**yes**', please provide details:

HIV/AIDS: Yes ☐ No ☐
If '**yes**', please provide details:

Tuberculosis: Yes ☐ No ☐
If '**yes**', please provide details: Date:

Mental illness: Yes ☐ No ☐
If '**yes**', please provide details:

Anxiety: Yes ☐ No ☐
If '**yes**', please provide details:

Depression: Yes ☐ No ☐
If '**yes**', please provide details:

Dementia/Alzheimer's: Yes ☐ No ☐
If '**yes**', please provide details:

Patient health questionnaire (continued)

Allevia Hospitals

Arthritis: Yes ☐ No ☐

If '**yes**', please provide details:

Joint implants or metalware: Yes ☐ No ☐

If '**yes**', please provide details:

Do you currently use:

Crutches: Yes ☐ No ☐

If '**yes**', please provide details:

Walking stick: Yes ☐ No ☐

If '**yes**', please provide details:

Walker or frame: Yes ☐ No ☐

If '**yes**', please provide details:

Wheelchair: Yes ☐ No ☐

Do you require any assistance to transfer? Yes ☐ No ☐

If '**yes**', please provide details:

Have you had any falls within the last 6 months? Yes ☐ No ☐

If '**yes**', please provide details: Date:

Heartburn/reflux: Yes ☐ No ☐

If '**yes**', please provide details:

Bowel conditions: Yes ☐ No ☐

If '**yes**', please provide details:

Bladder conditions: Yes ☐ No ☐

If '**yes**', please provide details:

Current skin problems e.g. ulcers, wounds, eczema, boils: Yes ☐ No ☐

If '**yes**', please provide details:

Do you have difficulty with your sight, hearing or communication? Yes ☐ No ☐

If '**yes**', please provide details:

Do you have any other medical conditions not already covered, or is there anything else we should know about you e.g. Parkinson's, muscle/nerve disease? Yes ☐ No ☐

If '**yes**', please provide details:

Do you or have you ever smoked? Yes ☐ No ☐

If '**yes**', how much? For how long? When did you give up?

Do you or have you ever vaped? Yes ☐ No ☐

How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2–4 times a month ☐ 2–3 times a week ☐ 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7–9 ☐ 10 or more

How often do you have 6 or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily/almost daily

Do you use recreational drugs? Yes ☐ No ☐

If '**yes**', what type? How often?

Do you have any special dietary requirements? Yes ☐ No ☐

If '**yes**', please provide details:

Do you have any religious beliefs/practices or cultural needs we should be aware of? Yes ☐ No ☐

If '**yes**', please provide details:

Discharge planning

Being prepared for your discharge is just as important as being prepared for your admission. As part of your discharge plan we will anticipate the day of discharge prior to your arrival at the hospital. This will relieve your anxiety and help you be ready for your discharge home.

You will need someone to stay with you for 24–48 hours after discharge.
This may be longer depending on your surgery.

Please complete the section below so we can see what care and support you will need to ensure a safe and speedy recovery.

Carer support

Current living arrangements?

☐ Live alone ☐ Live with others i.e. partner/children

Who will be caring for **you** following your discharge?

Name: _____ Relationship: _____

Do you have caring responsibilities for others at home? Yes ☐ No ☐

If '**yes**', please provide details: _____

If you are the sole caregiver for a dependant, you will need to consider making arrangements for their care during your hospital stay and after your discharge or as advised by your specialist.

Home supports

Do you currently receive any supports at home (i.e. home help, meals on wheels)? Yes ☐ No ☐

If '**yes**', please state what, and for how many hours per week: _____

If you think that you will require respite care for a period of time after discharge, please discuss this with your specialist. You may be responsible for any costs associated with this arrangement. **These arrangements should be organised by you prior to your admission.**

Discharge/transport

Please advise the person collecting you that the discharge time is **10am**.

Name: _____ Contact phone number (mobile/landline): _____

Please feel free to add any further comments/concerns regarding discharge:

_____

It is important to know **who** has **completed this form**. Please print and sign your name.

Name (print): _____ Date: _____

Signature: _____

I am the: ☐ Patient ☐ Legal guardian ☐ Parent ☐ Other (specify): _____