207 N US Highway 27, Suite A
Minneola FL 34715
Main: 352-432-3231
Fax: 352-404-8649

Intake Packet

Please fill out all of the following forms as best as you can before coming to your first session at Alive & Well Corp. Any information that you can give us is helpful so we can provide the best treatment possible. Thank you for taking the time to do this!

CLIENT INFORMATION SHEET

Client Name: _____ Date of Birth: _____

Parent/Legal Guardian if applicable: _____

Address:_____

City: _____ State: _____ ZIP:_____

Phone Number(s): _____

Emergency Contact Name: _____ Number: _____ Relationship: _____

Initial Date of Service: _____

Employed: ☐ Yes ☐ No Employer name: _____

Address of Employer: _____

City: _____ State: _____ ZIP:_____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ ZIP:_____

Telephone: _____ FAX:_____

Allergies: _____

Specific Health Conditions (we should be aware of): _____

Psychiatrist: _____

Address: _____

City: _____ State: _____ ZIP:_____

Telephone: _____ FAX:_____

Current Medications and dosage: _____

_____

Past Medications: _____

If you have other providers you would like us to be in contact with, please add their information:

_____

_____

Insurance Information and Financial Agreement Client Information:

Name: _____ Date of Birth: _____

Responsible party name: _____ Relationship to client: _____

Address:_____

City: _____ State: _____ ZIP:_____

Phone numbers: _____

OK to leave message?	**Home:**	☐ Yes	☐ No
	Work:	☐ Yes	☐ No
	Cell:	☐ Yes	☐ No

E-mail address:_____

**** If you are a self – pay client, please check the box below and move on to section of Therapist/Client agreement.**

Self -Pay - We offer a sliding scale fee for self-paying clients.

Sliding Scale Fee:

$35,000K and below its $35 per 50 min session
$36-$50K is $50 per 50 min session
$50K + is $75 per 50 min session

Proof of Income Includes:

- Pay stub.
- Bank Statements (personal & business)
- Copy of last year's federal tax return.
- Wages and tax statement (W-2 and/ or 1099)

If upon further verification is determined that the client's legal proof of income does not coincide with the original amount stated, Alive and Well reserves the right to bill the client for the remaining balance as it corresponds with our sliding scale fee.

Client must present legal proof of income no later than the second therapy session or services will be placed on hold until proper documentation is provided.

☐ I have read and understand the terms of the sliding scale fee and will provide the necessary document(s) needed.

_____ _____

Client Signature Date

IMPORTANT: It is essential that you fill out the rest of the form very carefully and that you give us all the necessary information regarding ALL of your insurances. Please note that if you do not give us accurate information you will then be responsible for payment.

I ONLY HAVE ONE INSURANCE and understand that if I have another one at any time and do not communicate the information to Alive & Well Corp, I might be responsible for payment in full.

☐ Yes

☐ No (If no, make sure you fill in all the information in the form below)

Insurance: Primary ID Number: _____ Group Number: _____

Insurance Company Name: _____ Insurance Phone Number: _____

Insurance Claim Address: _____

City: _____ State: _____ ZIP:_____

We get insurance through MEDICARE, the Military, or employment with a Federal government agency: ☐ YES or ☐ NO

Name of Policy Holder: _____ Relationship to client: _____

Address (If different from above):_____

City: _____ State: _____ ZIP:_____

Policy holder's /insured parent's: ID Number: _____

Social Security #: _____ Date of Birth: _____

(If Insurance is through Employer) Employer Name: _____

Employers address: _____

City: _____ State: _____ ZIP:_____

Important: In order to bill your insurance, we must have a copy of your insurance card on file.

Other Insurance(s). ID Number: _____ Group Number: _____

Insurance Company Name: _____ Insurance Phone Number: _____

Insurance Claim Address: _____

City: _____ State: _____ ZIP:_____

Name of Policy Holder: _____ Relationship to client: _____

Address (If different from above):_____

City: _____ State: _____ ZIP:_____

Policy Holder Social Security Number: _____ Policy Holder Date of Birth: _____

(If Insurance is through Employer): Employer Name: _____

Employer's address: _____

City: _____ State: _____ ZIP:_____

Financial Agreement:

• I understand and agree that it is my responsibility to understand my benefits for mental health services, to be aware of any co-payment, deductible, pre-authorization, or limits that apply to my plan, and to inform Alive & Well representative of these.

• I understand that any co-payment is due at the time of service.

• If my insurance coverage changes during the course of treatment, I agree to notify Alive & Well representative prior to the change.

• In the event that I fail to communicate any information regarding my insurance plan(s), co-pays, deductibles, preauthorization or changes, I agree that I will be responsible for any charges that are denied as a result.

• I understand that I am responsible for all charges whether or not paid by insurance. This includes amount reclaimed by insurances, whichever the date of the re-claim.

• I certify that I (or my dependent) have insurance coverage(s) as noted above and only these and I assign directly to Alive & Well Corp all insurance benefits, if any, otherwise payable to me for services rendered.

• I hereby authorize the healthcare provider to release to my insurance carrier and to the healthcare provider's billing service all information needed to secure the payment of benefits, and to mail patient's statements. I authorize the use of this signature on all insurance submissions.

• I certify that I have read and filled out this form completely to the best of my knowledge.

_____

Responsible Party Signature Relationship to client Date

THERAPIST / CLIENT SERVICE AGREEMENT

This document contains important information about Alive & Well Corp professional services and business policies. It also contains Client Rights and summary information about the Health Insurance Portability and Accountability Act (HIPPA) in the Notice of Privacy Practices. We are required by law to obtain your signature acknowledging that we have provided you with this information at the first session. Please read this document carefully and ask your therapist any questions you may have. When you sign the consent to treatment form, it will represent an agreement between us. It will include understanding of this document and your agreement to its content.

Client Rights

1. You have the right to request information about your therapist's qualifications, credentials, experience, specialization and education.

2. You have the right to obtain from another therapist a second opinion regarding the assessment and treatment plan developed to assist with your presenting problem.

3. You have the right to ask for an alternative referral at any time.

4. You have the right to inquire about fees for therapy, billing practices, insurance reimbursement, and other methods of payment.

5. You have the right to terminate therapy when you have reached your goals or believe therapy is no longer necessary.

6. You have the right to refuse the suggested intervention or treatment strategy indicated by your therapist.

7. The frequency and duration of therapy depends on many factors. It is your right to be part of determining jointly with your therapist how long and how often you will receive therapy.

8. You have the right to renegotiate therapy as often as needed.

9. You have the right to receive complete and accurate information regarding your diagnosis, treatment, risks and prognosis.

10. While exploring personal issues and making life changes you might experience emotional pain, discomfort and anxiety. You have the right to decide what to talk about and work on in and out of therapy. Nevertheless, your active participation will have the greatest positive effect on the outcome of therapy.

11. You have the right to confidentiality, unless you report to be in danger to yourself or others (Therapists must report to appropriate agencies if you are suicidal or homicidal). Limits also include misconduct of other mental health professionals, suspected abuse of children and vulnerable adults, prenatal exposure to controlled substances, court ordered reports, potential use of a collection agency, and insurance agencies. In these situations, there are limits to confidentiality.

12. If you are a minor, you have the right to request that data about you be kept from your parents. This request must be in writing. The request must include reasons for withholding information from parents. 13. If you are parent of a minor child, you have the right to access information unless a written request has been made by your child to deny access to information.

14. You have a right to see your file

15. If you are denied coverage by your insurance company, you may either continue treatment on a fee-for-service basis or terminate therapy with a referral.

In addition, HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that the therapist amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an account of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures.

Professional Fees

1. Fifty (50 minutes) of family/couples $90.00 or individual therapy $75.00.
2. Clients utilizing insurance are responsible for their co-pay and deductible at the time of service.
3. If the client is not utilizing insurance, full fee is expected at the time of service.
4. Failure to show for an appointment without cancelling may be subject to a charge of $25.00.
5. It is the client's responsibility to be aware of insurance coverage. Any changes not covered by insurance become the liability of the client.

Contacting your therapist:

To schedule an appointment please contact your therapist directly. Since we are often seeing other clients you may reach our voicemail. Please leave a message with your phone number and a good time to reach you. When we are in the office, we check our messages throughout the day. The exceptions to this are on weekends, holidays, or when a therapist is sick or on vacation. Therapist's voicemail message will be updated periodically as needed. In an emergency, you will be directed to contact your physician, an emergency room or 911.

Limits on Confidentiality

In most situations, we can only release information about you to others if you sign a Release of Information that meets certain legal requirements. Your signature on the Consent to Treatment Form provides consent for the following activities:

• Consultation with other health and mental health professionals during which we make every effort to avoid revealing the identity of clients. The other professionals are also legally bound to keep the information confidential.

• Disclosures required by health insurers. There are other situations in which we are legally obligated to take actions such as in cases of possible child abuse, neglect or self-harm. These limits and uses are detailed further in the Notice of Privacy Practices.

CONSENT TO TREATMENT FORM

By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Alive & Well Corp will not render services to your child until the therapist has received and reviewed a copy of the most recent applicable court order.

_____ _____ _____

Signature – Client | Print Name | Date

_____ _____ _____

Signature – Spouse/Partner/Parent | Print Name | Date

_____ _____

Signature – Witness | Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____ _____

Signature – Client/Parent | Date

I authorize the payment of medical benefits to the provider of services.

_____ _____

Signature – Client/Parent | Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI").

This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy

Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by

HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW*

Code of Ethics and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect, when disclosure is mandated by the Child Abuse and Neglect or Elder/Dependent Adult Abuse Reporting law.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Clients. We may disclose PHI regarding deceased clients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased clients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us.

We may prepare a rebuttal to your statement and will provide you with a copy. Please contact our office if you have any questions.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice. You have the right to a copy of this notice.

Complaints. Please contact HIPPA Toll Free Call Center: 1-800-368-1019

_____ _____

Signature **Date**

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient name: _____ Date of Birth: _____

Address:_____

City: _____ State: _____ ZIP:_____

SECTION A: The Use and/or Disclosure Being Authorized

Protected Health Information to be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing to be used and/or disclosed:

(Check all that apply)

☐ Discharge Summary

☐ Biopsychosocial Assessment

☐ Treatment Plan Evaluation

☐ Progress Summary

☐ Other: _____

_____

SECTION B: Entities Authorized to Receive, Use or Disclose:

Name or specifically identify the persons or organizations (or the classes of persons and/or organizations), including Alive and Well, who you are authorizing to receive, to make use of, and/or to disclose the protected health information described above:

I authorize information to be: ☐ Released **From Alive and Well, Corp To**

(Name/Title/Organization) (Address)

_____ _____

(*Receipt of protected health information is limited to one health care provider per authorization form.*)

I authorize information to be: ☐ Released **To Alive and Well, Corp From**

(Name/Title/Organization) (Address)

_____ _____

(*Receipt of protected health information is limited to one health care provider per authorization form.*)

SECTION C: Purpose

The information is being used/disclosed for the following purpose:_____

_____

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Alive and Well Office Assistant. I understand that revocation of this authorization will not affect any action taken by Alive and Well in reliance on this authorization before my written notice of revocation was received. Written revocation should be sent to:

Alive and Well Office Assistant; 207 N US Highway 27; Minneola, FL 34715; 352-432-3231

SECTION D: The Patient (or the Patient's Legal Representative) Confirming the Authorization

I understand that: this authorization is voluntary (you may refuse to sign); my health care and payment for my health care will not be affected if I do not sign this form; if the organization authorized to receive and/or use the information is not a health plan, health care provider, or health care clearinghouse subject to federal health information privacy laws, the released information may no longer be protected by federal privacy. information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and no longer protected.

SIGNATURE:

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Alive and Well. I understand that, by signing this form, I am confirming my authorization that Madison State Hospital may receive, use, and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature of Client:_____ Date:_____

Signature of Legal Representative: _____

PART 2:

This information is from records whose confidentiality is protected by federal law. Federal regulations (Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of other information is not for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT

Service Agreement

Agreement I: Purchase of Service
I, the undersigned, agree to use the purchased services of Alive and Well within 60 days of the purchase date. If services are not rendered, per the undersigned, after the 60th day of purchase, I, the undersigned, will relinquish any claim for a refund, per this 60 day purchase of service term agreement.

Agreement II: Cancellation / Late
Alive and Well Corp. understands that unexpected events arise in the lives of our clients: E.g. transportation complications, illness, child care matters, etc.). In our desire to be effective and fair to all of our clients, and out of consideration for our therapist's time, we have adopted and require the following policies:

- In most cases, a 24-hour advance notice is required when canceling an individual appointment. This allows the opportunity for someone else to avail themselves of our services.
- If you are unable to give us the minimum 24-hours advance notice, and we are unable to fill your time slot, you will be charged in the amount of $25. At our discretion this charge will be either automatically deducted from the authorized payment medium or paid in full prior to your next treatment.
    - *If an individual does not have a payment method on file and/or funds are not tendered to Alive and well within 30 days of the cancelation notice, a claim will be filed for collections.*
- If you arrive later than 15 minutes, without prior acknowledgement, from your scheduled session with a therapist, it will be the discretion of the therapist if you can be treated for services. Furthermore, if you are seen by the therapist, despite being late, the full allotted time may not be actualized if there is a client scheduled within a half hour after your initially scheduled session. after your set appointment.

By signing below I, the undersigned, acknowledge that I have fully read and understood this Purchase of Services agreement and agree with its contents.

_____ _____

(Print, First and Last Name) (Alive and Well Representative)

_____

(Please Sign)

Treatment Plan

Date: _____ Client's Name: _____

All treatment goals must be objective and measurable with estimated time frames for completion. Goals are to be established within first 2 weeks of initiating treatment and they are valid for six months. If all goals are met by six month mark, new treatment plan will be created. An addendum form will be created if there are any changes. The treatment plan is to be developed with the client, and their signature represents understanding and agreement of the treatment plan.

My therapist and I will develop a plan together, and I am in agreement to working on these issues and goals.

Client's Signature_____ Date_____

Client's Signature_____ Date_____

Parent/ Guardian Signature if applicable_____ Date_____

Clinician's Signature_____ Date_____

CREDIT/DEBIT CARD AUTHORIZATION FORM

All clients are required to complete this mandatory authorization form prior to initial intake / first session of service. Services will not be provided until this form has been completed in its entirety.

All service payments are due prior to the beginning of every session. Client's may choose to pay in cash, check, or card. If payment for service is unable to be processed (due to card decline, or error with insurance reimbursement, etc.), we will attempt to reach you a total of 3 times by phone or email. If we are unable to reach you, and hear no response, we will at that time proceed to charge your card on file.

Alive and Well reserves the right to use card information on file for any outstanding balance due. Keep in mind, we will be as fair as possible to give all clients an opportunity to set up a payment plan if needed.

This form can also be used for your convenience to pay for sessions that are out of office, and/or re-occurring sessions and co-pays.

After completion of therapy and payments have been fully processed, all of client's card information with be discarded.

CARDHOLDER INFORMATION

Name:_____

Billing Street Address:_____

City: _____ State: _____ ZIP:_____

Country:_____Email: _____

Direct Telephone:_____

CREDIT/DEBIT CARD INFORMATION

Credit/Debit Card Type: ☐ MasterCard ☐ Visa ☐ Discover Card ☐ American Express

Number:_____

Expiration Month:_____Expiration Year:_____Security Code:_____

Cardholder Signature X_____ Date: _____/_____/_____