PATIENT INFORMATION AND CONSENT TO PROVIDE TREATMENT

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PATIENT INFORMATION / PRIMARY HOUSEHOLD

Patient Name:	**Date of Birth:**
Parent (s) / Guardian:	
Street Address:	
City / State:	**Zip:**
Primary Phone:	**Leave message:** □ **Yes** □ **No**
Secondary Phone:	**Leave message:** □ **Yes** □ **No**
Preferred E-Mail:	**Appointment Reminders:** □ **Yes** □ **No**

SECONDARY HOUSEHOLD

Parent/Guardian:		
Street Address:		
City / State:	**Zip:**	
Primary Phone:	**Leave message:**	□ **Yes** □ **No**
Has this individual been notified that you are seeking treatment for your child?		□ **Yes** □ **No**
Have they verbalized agreement with this decision?		□ **Yes** □ **No**

INSURANCE INFORMATION

Primary Insurance:	**Primary Insured:**
ID Number:	**Primary Insured Date of Birth:**
Group Number:	**Employer:**
Guarantor:	**Guarantor SS#:**

CONSENT FOR TREATMENT: I authorize and request my practitioner to carry out psychological exams, treatment and/or diagnostic procedures which are now, or during the course of treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment.

GENERAL CONSENT FOR DEPENDENT TREATMENT: I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner to deliver mental health services to the patient. I also understand that all policies described in this statement and the Service Agreement apply to the patient I represent.

RELEASE OF INFORMATION: I authorize release of information to my Primary Care Physician, other health care providers, institutions and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. If I am an insured client, I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

GUARANTOR STATEMENT: In consideration of the services provided, I hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of service. In the event of default in payment, reasonable collection agency fees equal to 30% of the delinquent balance and reasonable attorney fees shall be added to the amount due on the account, plus any applicable court costs. By providing my cell number, I give prior express consent to receive calls and text messages from the creditor or its third party debt collector at that number, including calls and messages made by using an auto-dialer or prerecorded message.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMED CONSENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED IN THE SERVICE AGREEMENT.

Signature of Legal Representative / Date _____