Reset Form Print Form

BALDWIN COUNSELING

1492 South Independence Blvd. Suite 104 Virginia Beach, VA 23462
Office: (757) 340-0275 Fax: (757) 340-0276

BALDWIN COUNSELING CONSENT FOR TREATMENT

PATIENT Name (last/first/MI) Month Patient First Name Middle Initial

PATIENT Date of birth ___ ___ Month ___ ___ ___ ___

I, Patient OR Parent/Legal Guardian, (Patient OR parent/legal guardian of minor client under 18)

_____**(initial)** Have read and understand the contents of the **Virginia Notice Form** (*A copy of this notice will be provided upon request and is available on the website, www.baldwincounselingcenter.com.)* regarding the Protected Health Information (PHI) held by Baldwin Counseling for requested services. I understand this information will be handled in accordance with the HIPAA Privacy Rule, which affords me specific rights and responsibilities regarding my PHI.

_____**(initial)** Have read and understand the contents of the **Notice of Privacy Practices**. (*A copy of this notice is available on the website, www.baldwincounselingcenter.com, and will be provided upon request).*

_____ **(initial)** Give Informed Consent to Treatment My consent indicates a commitment to enter treatment with the understanding of the basic ideas, goals, and methods of this therapy. I consent to keep the therapist up to date about any changes in symptoms or situation that may impact the success of treatment. I understand that with periodic evaluation of these goals, therapy may change to best serve my long-term interest.

_____ **(initial)** Understand that psychotherapy may arouse unpleasant feelings and emotional experiences, particularly in the initial phase of treatment. Relationships with significant others may also undergo substantial change during the course of treatment. If treatment is terminated, I agree to schedule a closing session with the therapist to discuss progress, outcomes of treatment, and any further clinical recommendations.

_____ **(initial)** In working with children, the child is the identified client. Under most circumstances, parents/guardians have a right to the medical record. The parent is giving consent for the therapist at Baldwin Counseling, P.L.L.C. to provide clinical services to a minor child.

_____ **(initial)** Only the person who makes an appointment may cancel the appointment.

_____ **(initial)** If the child has a court appointed Guardian ad litem, the therapist will obtain a copy of the court order and will provide all requested information to the GAL as permitted by the law.

_____ **(initial)** While legally parent with legal custody can consent to treatment, under most circumstances, Baldwin Counseling, P.L.L.C. does not provide treatment to a child if one parent refuses for the child to be seen. A letter of intent for the child to receive counseling for the parent who refused treatment prior to the child being re-enrolled in therapy at Baldwin Counseling, P.L.L.C.

_____ **(initial)** Licensed clinicians are mandated reporters in the state of Virginia. If there is a *suspicion* of abuse or neglect, the necessary reports will be made. If the child is in danger, necessary actions will be taken that may include notifying the local police authorities, Child Protective Services, and parents/guardians. Per state regulation, confidentiality cannot be maintained in these situations.

_____ **(initial)** Only the parents/guardians/other legally designated custodians and the Guardian ad litem have rights to information about the child unless appropriate consents are signed.

_____ **(initial)** If a subpoena for testimony is received, it is understood that the therapist must attend the scheduled hearing and respond to information requested.

_____ **(initial)** Du**e** to the requirements of billing, one person in the family is the designated client and all notes will be recorded in his/her chart.

_____ **(initial)** The designated client must provide releases for anyone present in the family session other than the client. If the client is a child, the parent who has legal custody must provide consents for anyone participating who does not have legal custody.

_____ **(initial)** The clinician is obligated to maintain the same standards of confidentiality and mandated reporting obligations during family therapy as in individual therapy.

_____ **(initial)** The clinician cannot guarantee that the content of family therapy other than the mandated HIPPA compliance required of the clinician. The clinician cannot guarantee that participants in family therapy will maintain confidentiality.

_____ **(initial)** The clinician will encourage confidentiality in the family session but is not responsible if a member in the session does not respect this.

PRINTED NAME: Date _____

SIGNATURE _____ **DATE** Date _____

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CONSENT TO CONTACT

May we contact you by phone? ***Please check YES or NO below***

☐ **NO**, you may not contact me by phone or through email for appointment reminders or notify me of cancellations by leaving a phone message or an electronic mail. I *will be responsible for keeping scheduled appointments and I understand that a missed appointment fee may be charged for appointments cancelled less than 24 hours in advance or for not showing up for an appointment.*

☑ **YES**, you may contact me for appointment reminders and/or to notify me of a cancellation by leaving a phone message or email at the provided contact information.

Automatic Computer Reminder Calls: Are scheduled to be sent prior to your appointment to the preferred number. Baldwin Counseling is not responsible for this service; it is a courtesy call or text. The computerized system will send out a reminder forty-eight hours prior to your scheduled appointment. You may opt for either text or voice mail. The system allows for additional notification via email to any designated email address. The patient or parent who signs the payment agreement and this form will receive the automated calls or text messages.

If you do not receive an automated reminder forty-eight hours before the scheduled appointment day, call the office to verify that there is an appointment scheduled

My Preferred contact is ☐ Cell ☐ Home ☐ Work ☐ Email _____ .

CELL NUMBER Home Number

HOME NUMBER Home Number

WORK NUMBER Home Number

EMAIL eMail Address

_____
Signature of Patient or Responsible Party

Client Name	Relationship	Date
Printed Name	Relationship to patient	Date

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BALDWIN COUNSELING
Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name: Client Name _____

DOB: Date of Birth _____

This Notice contains important information about the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your personal health information. The law requires that we obtain your signature acknowledging that we have provided you with this information.

HIPPA NOTIFICATION

Notice of Social Work Policies and Practices to Protect the Privacy of Your Health Information

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

Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"

-Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist.

-Payment is when we help you to obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to help you to obtain reimbursement for your health care or to determine eligibility or coverage.

-Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "Use" applies only to activities within our practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes your therapist has made about your conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have reason to suspect that a child is abused or neglected, we are required by law to report the matter immediately to the Virginia Department of Social Services.

- **Adult and Domestic Abuse:** If we have reason to suspect that an adult sixty-five or older is abused, neglected or exploited, we are required by law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.

- **Health Oversight:** The Virginia Board of Social Work has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legal representative, or a subpoena (of which has been properly served, along with the proper notice required by state law). However, if you move to quash (block) the subpoena, we are required to place said records in a sealed envelope and provide them to the clerk of court of the appropriate jurisdiction so that the court can determine whether the records should be released. At times, the confidentiality privilege does not apply when you are being evaluated for a third-party report or where the evaluation is court ordered. You will be informed in advance, if this is the case.

- **Serious Threat to Health or Safety:** If your therapist is engaged in his/her professional duties and you communicate to him/her a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and your therapist believes you have the intent and ability to carry out that threat immediately or imminently, he/she must take steps to protect third parties. These

precautions may include (1) warning the potential victim(s), and/ or the parent or guardian of the potential victim(s), if under 18; or (2) notifying a law enforcement officer.

• **Worker's Compensation:** If you file a worker's compensation claim, we are required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

I. Patient's Rights and Social Worker's Duties

Patient's Rights:

- *Right to Request Restrictions* -You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know you are being seen. Upon your request, we will send your bills to another address.)
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, your doctor will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, your doctor will discuss with you the details of the amendment process.
- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice).
- On your request, your doctor will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically. There is an applicable charge for records provided in paper form.

Social Worker's Duties

The clinician is required by law to maintain the privacy of PHI and to provide you with a notice of his/her legal duties and privacy practices with respect to PHI.

- The clinician reserves the right to make changes to this notice upon changes in the Privacy Rule Law.
- Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, an updated copy will be available in the office.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Dr. Suzanne Baldwin.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Our office can provide you with the appropriate address upon request.

Restrictions and Changes to Privacy Policy

We respect your privacy and the confidentiality of any personal information you discuss with us. In areas where your consent is not necessary, please be assured that we will nevertheless continue as always to make every effort possible not to share information about you without your knowledge.

In the event of procedural changes in our practice and/or any changes in the Privacy law, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that we maintain. The newly updated form will be posted in the office waiting room and a copy will be provided to you upon request.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Baldwin Counseling's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my Privacy Rights, I can contact Dr. Suzanne Baldwin and/or Baldwin Counseling, P.L.L.C.

Date

Signature of Patient/Client **Date**

Date

Signature or Parent, Guardian or Personal Representative **Date**

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, DHS representative, etc.) and provide appropriate documentation.

☐ **Client or Authorized Representative Refuses to Acknowledge/Sign Notice of Privacy Practices**

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POLICIES AND FEE AGREEMENT FOR WITNESS TESTIMONY AND RELATED SERVICES

This document confirms that a Baldwin Counseling therapist may be asked by the undersigned client (or the parent/guardian of the client) to provide additional services related to litigation involving the client or the parent/guardian. It describes procedures and sets forth our agreement regarding payment of the costs and fees associated with those services.

Hourly Rate. The clinical therapist's current rate for services rendered specific to litigation is $200.00 per hour. Baldwin Counseling reserves the right to increase that rate in the future, but advance notice will be provided of any increase. All work is billed in fifteen-minute increments.

Billable Time. All time spent regarding the litigation of the client's case will be billed at the hourly rate listed above. That time may include, but is not limited to, participating in conferences and/or telephone conversations related to the case, drafting, and reviewing correspondence and/or emails, reviewing records or other materials, doing research, rescheduling other clients' appointments to reserve the clinical therapist's time for court appearances and/or depositions, conducting clinical interviews, participating in depositions, drafting reports, travelling and/or appearing in court.

Court Appearances. Unless other arrangements have been made in writing or email and in advance, the clinical therapist will not appear in court unless a valid witness subpoena has been issued.

If the subpoena is issued less than fifteen calendar (15) days prior to the scheduled hearing, the fee rate for services will be $225.00 per hour. If the subpoena is issued less than five calendar (5) days before the scheduled hearing, the fee is $300.00 per hour. Initial fees for the court appearance ($800.00) are due immediately if the subpoena is received less than fifteen calendar days.

The party requesting the clinical therapist's presence at court (including the party on whose behalf an attorney issued a witness subpoena) shall be liable for all Billable Time associated with the court appearance. The fees for all Billable Time shall be paid (e.g., court preparation, client cancellations and other expenses), even if the case settles or the clinical therapist's testimony is ultimately deemed to be unnecessary.

Payment Schedule for Court Appearances

Initial Deposit. No less than fifteen (15) days before the date on which the clinical therapist is to attend court, the party requesting the clinical therapist's appearance (including the party on whose behalf an attorney issued a witness subpoena) shall pay to Baldwin Counseling the sum of $800.00 to be applied to the Invoice for all Billable Time. $600.00 of the Initial Deposit is non-refundable. If the subpoena is issued less than 15 calendar days, the entire deposit is required immediately.

Invoice. Following the clinical therapist's appearance in court or her receipt of notice that her appearance is not required, Baldwin Counseling will remit an invoice for the balance due for all Billable Time. The Initial Deposit will be credited to the total fees incurred. Any remaining balance shall be paid by the party requesting the clinical therapist's appearance (including the party on whose behalf an attorney issued a witness subpoena) within thirty (30) days of the date of the Invoice. In the event the balance of the Invoice is less than the refundable portion of the Initial Deposit, Baldwin Counseling will refund the difference to the party who paid the deposit within thirty (30) days of the date of the Invoice.

Payment Schedule for Depositions

Initial Deposit. No less than fifteen (15) days before the date on which the clinical therapist's deposition is to be taken, the party taking the clinical therapist's deposition (including the party on whose behalf an attorney issued the deposition notice and/or witness subpoena) shall pay to Baldwin Counseling the sum of $800.00 to be applied to the Invoice for all Billable Time. Six hundred ($600.00) of the Initial Deposit is non-refundable.

Invoice. Following the clinical therapist's deposition or her receipt of notice that the deposition has been canceled, Baldwin Counseling will remit an Invoice for the balance due for all Billable Time. The Initial Deposit will be credited to the total fees incurred. Any remaining balance shall be paid by the party on whose behalf the clinical therapist's deposition was requested and/or taken within thirty (30) days of the date of the Invoice. In the event the balance of the Invoice is less than the refundable portion of the Initial Deposit, Baldwin Counseling will refund the difference to the party who paid the deposit within thirty (30) days of the date of the court hearing.

Written Reports

In the event a party or his/her attorney requests a written report, the party on whose behalf the report was requested shall be liable for all Billable Time associated with writing that report.

Procedure for Requesting a Written Report. A report must be requested, in writing or email, at least twenty-one (21) days before the report is due.

All requests for written reports shall include a due date for submission, which shall be at least twenty-one (21) days after the date of the request. Baldwin Counseling reserves the right to refuse to prepare a written report in response to any request received less than twenty-one (21) days in advance. Baldwin Counseling reserves the right to decline writing a report based on clinical determination.

In the event a request does not specify a due date for submission, the completion date of the report and the due date for the payments of the Initial Deposit and Invoice shall be designated at the sole discretion of Baldwin Counseling.

Written reports will not be provided to a third party unless Baldwin Counseling has received a valid release or a subpoena duces tecum that is compliant with HIPAA (the Health Insurance Portability and Accountability Act).

Initial Deposit. No later than twenty-one (21) days before the due date for the submission of the written report, the party requesting the report (including the party on whose behalf an attorney requested the report) shall pay to Baldwin Counseling the sum of $800.00 to be applied to the invoice for all Billable Time spent preparing the report. Six hundred ($600.00) of the Initial Deposit is non-refundable.

Invoice. Upon completion of the written report and no later than the due date for submission designated in the request, Baldwin Counseling will provide to the party requesting the report (or to the attorney who requested the report) an invoice for all Billable Time spent preparing the report. The Initial Deposit will be credited to the total fees incurred. *Any remaining balance* shall be paid by the party who requested the report (including the party on whose behalf an attorney requested the report) and *must be received by Baldwin Counseling before the written report will be released*. In the event the balance of the Invoice is less than the refundable portion of the Initial Deposit, Baldwin Counseling will refund the difference to the party who paid the deposit within thirty (30) days of the date of the Invoice.

Unless other arrangements are made in advance, the report will be mailed to the party or attorney who requested the report on the due date or within two (2) business days after receipt of the payment for the written report, whichever is later.

Copying Fees and Procedures. Copies of the client's records will be provided upon request, in writing, based on clinical and legal protocols. Unless special arrangements have been made in advance, which may include payment of a rush fee, records will be available ten (10) business days after the request is received by Baldwin Counseling. Client records will not be sent by electronic mail to parents/guardians.

Except as otherwise stated in this Agreement, copies of the client's records will not be sent to any third party, including any attorney, unless Baldwin Counseling receives a valid release or a subpoena duces tecum that is compliant with HIPAA (the Health Insurance Portability and Accountability Act). Copies of a client's records will be released to the client's duly authorized Guardian *ad Litem*, provided Baldwin Counseling has received a copy of the Guardian *ad Litem*'s Order of Appointment, in advance.

The party requesting copies of the client's records (defined as the party who requested the records, the party who signs a release, the party who requests a subpoena duces tecum and/or the party on whose behalf an attorney issued a subpoena duces tecum or other request for records) shall be liable for the reasonable charges for the service of maintaining, retrieving, reviewing, preparing, copying and/or mailing the records. Such charges shall include a search and handling fee of $10 per request, and copying fees of $0.50 for each page up to 50 pages and $0.25 per page thereafter. Payment for

the copying fees must be received by Baldwin Counseling before the records will be provided to anyone.

Baldwin Counseling will notify the party requesting copies of the client's records of the cost of the copies. Unless other arrangements are made, the records will be available to be picked up upon payment of the copying fee. It is mandatory to call first to confirm a time to pick up the records. A therapeutic session will NOT be disrupted to facilitate pick-up of records.

Copies that have not been picked up or otherwise delivered within 90 days from the date payment is received will be shredded. If the records were not picked up within 90 days, a new request must be made and payment of new copying costs and fees must be rendered before the records may be obtained.

Past Due Invoices. Invoices that remain due and unpaid for more than thirty days shall accrue interest at the rate of 6% per annum. In the event collection proceedings are instituted to collect the amounts due pursuant to this agreement, the party requesting any services outlined in this Agreement (including the party on whose behalf an attorney requested such services) shall be liable for all attorney's fees and costs incurred by Baldwin Counseling which shall not be less than the actual amount billed or 25% of the past due amount, whichever is greater.

Any report, testimony or other information provided by the clinical therapist and/or Baldwin Counseling shall conform to ethical standards of practice. The party requesting such information is not guaranteed any particular result and payment of any of the fees set forth in this Agreement does not entitle the party making such request(s) to receive any particular result, testimony or recommendation by the clinical therapist or Baldwin Counseling.

NAME OF CLIENT: Client Name

I, My Name, am the

☐ Client ☐ Parent of Client ☐ Legal Custodian of Client

I have read and understand this Policies and Fee Agreement for Witness Testimony and Related Services. I am signing this Agreement knowingly, intelligently, and voluntarily and agree to be bound by its terms.

Printed Name: Printed Name

Date Signature of Client or Client's Parent/Legal Custodian

Date

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BALDWIN COUNSELING
Consent to Release Information to
Primary Care Physician (PCP) or Primary Care Manager (PCM)
Insurance companies require the patient to complete the PCP Release form

This is Only for Primary Care Physicians.

Last First MI SS Number Patient DOB

Name of Patient (Last, First, MI) Patient Social Security Number Patient Date of Birth

Do you want your therapist to communicate with your PCP or PCM.

Please check ONE of the following

☐ **NO**, **I DO NOT** give consent to release information to my PCP/ PCM *(Please skip to section 3)*

☐ **YES**, **I DO** give consent to release information to my PCP/PCM *(Please complete ALL info in section 2 & 3)*

If you checked YES, ***please complete the following:***

I hereby give my informed consent for **Baldwin Counseling P.L.L.C.**

☐ Talk with Physician

☐ **Release written documentation**

☐ **Both**

The client or parent MUST complete this section:

Primary Care Physician or Primary Care or Manager Primary Care Manager

Address Address

Phone Fax **Fax** Fax

3. Patient Authorization:

I understand:

- This authorization may be revoked at any time by submitting a written request. Disclosure(s) made prior to receipt of revocation are authorized under the prior authorization.
- My refusal to release records will not affect my ability to obtain treatment**.**
- If a person or facility receiving the above stated information is not a healthcare or insurance provider covered by HIPAA Privacy Regulations this information could be re-disclosed.

Date Last First MI Relationship

Signature of Patient *(Or responsible Party if Patient is a Minor)* Date Printed Name (last, first, MI) Relationship to patient

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CONSENT TO PARTICIPATE IN A TELEHEALTH CONSULTATION

PROVIDER'S NAME AND CREDENTIALS: Suzanne M. Baldwin, Ph.D., LCSW, RN

Patient Name: Patient Name _____ Date of Birth DOB

1. I understand that my health care provider wishes for me to engage in telehealth consultation. I hereby consent to forward my patient-identifiable information to a third party for HIPPA video conferencing. I understand that it is the role of the health care provider to determine whether the condition being diagnosed and/or treated is appropriate for telehealth encounter. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are inadequate for the situation.
2. ***The client must be in the State of Virginia during the session.***
3. My health care provider has explained to me how the video conferencing technology will be used and the telehealth services can include appointment scheduling, taking payment, patient education, psychotherapy, despite not being in the same room as my health care provider.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I also understand that all audio, video, file sharing, and chat features require password protection and use the latest encryption protocols to assume that data integrity and privacy are maintained. I will hold the health care provider harmless for information lost due to technical failures.
5. I have had the alternatives to telehealth consultation explained to me, and in choosing to participate in a telehealth consultation, I also understand that some parts of the consultation may require an in-person office visit.
6. In an emergent consultation, I understand that the responsibility of the healthcare provider is to notify my local provider or emergency services and that my healthcare provider's responsibility will conclude upon the termination of the video conference connection. It is my responsibility to notify my provider of my physical location during each meeting.
7. I understand that billing will occur just the same as in-person visits and I am responsible for all charges not covered by insurer as per the previously signed financial agreement.
8. I have had a direct conversation with my healthcare provider during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.
9. This authorization expires one year from the date signed.

By signing this form, I certify that I have read or had this form read and/or had this form explained to me. I certify that I understand its contents including risks and benefits of the procedure(s). I certify that I have been given ample opportunity to ask any questions and that any questions have been answered to my satisfaction.

_____ Date _____

Patient/Parent/Guardian Date

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Contact and Insurance Information

Client Name: Name _____ **Age:** Age _____ **Date:** __ __ Date

Parent/Guardian:
Name: Name _____ Relationship to Client: Relationship _____
Phone Number: Phone _____ Email: eMail _____

Parent/Guardian:
Name: Name _____ Relationship to Client: Relationship _____
Phone Number: Phone _____ Email: eMail _____

Parent/Guardian:
Name: Name _____ Relationship to Client: Relationship _____
Phone Number: Phone _____ Email: eMail _____

Guardian *ad Litum*:
Name: Name _____ Phone: Phone _____
Email: eMail _____

Primary Insurance: Secondary Insurance _____
Member ID# Member ID _____ Effective Date: Effective Date _____

Secondary Insurance: Secondary Insurance _____
Member ID#: Member ID _____ Effective Date: Effective Date _____

Notes:
Notes