

Date: _____ **Referral Source:** Insurance/Managed Care Referral Internet Search Phone Book
 Physician (Name) _____ Friend/Family Our Website Other: _____
 Professional Referral (e.g. the name of the referring therapist, attorney, pastor): _____

CLIENT INFORMATION

CLIENT NAME: (Last) _____ (First) _____ (M.I.) _____
 Male Female Age: _____ DOB: _____ SS#: _____
Primary Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ **Youth Cell:** _____
Youth Employment Status: Full-time Part-time **Employer:** _____
Present School: _____ **Present Grade:** _____ **Teacher:** _____
Primary Care Physician: _____ **Address:** _____ **Office #** _____
Reason for seeking service: _____

1. Parent/Guardian bringing child/teen for treatment: Custodial Parent Non-Custodial Parent Legal Guardian
 Name: _____ DOB: _____ Male Female SS#: _____

Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work: _____ Cell: _____

Place of Employment: _____ Full-time Part-time Occupation: _____

Does Client live at this address? _____ When? _____ List others living at this address:

Name	Sex	DOB	Age	Relation to client
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Additional Parent/Guardian: Custodial Parent Non-Custodial Parent Legal Guardian
 Name: _____ DOB: _____ Male Female SS#: _____

Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work: _____ Cell: _____

Place of Employment: _____ Full-time Part-time Occupation: _____

Does Client live at this address? _____ When? _____ List others living at this address:

Name	Sex	DOB	Age	Relation to client
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. Additional Parent/Guardian: Custodial Parent Non-Custodial Parent Legal Guardian
 Name: _____ DOB: _____ Male Female SS#: _____

Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work: _____ Cell: _____

Place of Employment: _____ Full-time Part-time Occupation: _____

Does Client live at this address? _____ When? _____ List others living at this address:

Name	Sex	DOB	Age	Relation to client
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Emergency Contact Information

Name: _____ Relationship to Client: _____

Home#: _____ Work#: _____ Additional #: _____

Please continue on back

PLEASE NOTE: The person who brings the child for treatment is responsible for the payment of any and all fees associated with services rendered to the child through Positive Perspectives, Inc. We understand that this policy may differ from a court-ordered payment arrangement. _____ (Initial)

INSURANCE INFORMATION

Primary Insurance Co. _____	Employer _____
Policyholder Name _____	SS# _____
Policy ID# _____	Group Number or Code _____
Insured DOB _____	
Insured's Address if different than Client: _____	
Secondary Insurance Co. _____	Employer _____
Policyholder Name _____	SS# _____
Policy ID# _____	Group Number or Code _____
Insured DOB _____	
Insured's Address if different than Client: _____	

YOUR RIGHTS AND THE RIGHTS OF MINORS AND PARENTS

HIPAA provides you with rights which include: requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting 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/Notice form. In addition, parents and clients under 14 years of age who are not emancipated should be aware that the law allows parents to examine their child's treatment records unless the child's therapist decides that such access would injure the child. Children between 14 and 18 may independently consent to and receive up to 6 sessions of psychotherapy (provided within a 30-day period) and no information about those sessions can be disclosed to anyone without the child's agreement. While privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, parental involvement is also essential to successful treatment. _____ (Initial)

A REMINDER REGARDING THE RIGHTS OF NON-CUSTODIAL PARENTS

Please be aware that the rights of a Non-Custodial parent are no different than a Custodial Parent when dealing with the child's records, communication with the therapist, or other related matters. However, a Non-Custodial parent may be given access only to the information that applies to *the child*; any information about any other parties (such as the Custodial Parent) may only be given with explicit written permission. *For the child's protection, personal identification and a copy of the divorce decree may be required in order to verify legal access to the child's records.* _____ (Initial)

AUTHORIZATION AND PERMISSION TO TREAT

I hereby grant authorization to Positive Perspectives, Inc. to release any Protected Health Information (except Psychotherapy Notes) to my insurance company that is necessary for billing, or to process my claim for payment of services. I authorize my insurance company to send payment directly to Positive Perspectives for all services provided. I also authorize Positive Perspectives to release claim forms and supporting documentation to the Ohio Department of Insurance if Positive Perspectives files a claim against my insurance company under the Ohio Prompt Payment Law. I agree that a photocopy of this authorization shall be as valid as the original.

I hereby consent for Positive Perspectives, Inc. to provide treatment and evaluation to:

Name of Client

Signature of Parent/Guardian

Date

Print Name of Parent/Guardian

Relationship to the Child