



Minor Client Client Information Form

PATIENT INFORMATION

First Name _____ Middle _____ Last _____
Preferred Name _____ Date of birth _____
Mailing address _____ City _____ St _____ Zip _____
Physical address _____ City _____ St _____ Zip _____
Mobile phone _____ Accept texts? Yes ☐ No ☐ Leave voice mail? Yes ☐ No ☐
Home phone _____ Leave voice mail? Yes ☐ No ☐
E-mail _____
Birth Sex _____ Race ☐ American Indian or Alaska Native
Gender Identity _____ ☐ Asian
Sexual Orientation _____ ☐ Black or African American
Marital Status ☐ Married ☐ Single ☐ Other ☐ Hispanic or Latino
☐ Employed ☐ Unemployed/Other ☐ Native Hawaiian or Other Pacific Islander
☐ Full-Time Student ☐ Part-Time Student ☐ White
☐ Choose not to disclose

PARENT/GUARDIAN INFORMATION & PERMISSIONS

Parent/Guardian 1

Name _____ Relation to client _____
Custodial ☐ Yes ☐ No ☐ Shared *please explain arrangement* _____
Responsible Party for Billing ☐ Yes ☐ No
If financially responsibility is split with another party, please explain arrangement _____
Mobile Phone _____ Home Phone _____ Work Phone _____
Mailing address _____ City _____ St _____ Zip _____
What information may we share with this contact?
☐ Scheduling Information ☐ Diagnosis ☐ Substance Abuse Notes
☐ Billing Information ☐ Session Notes ☐ Psychological Evaluation

Parent/Guardian 2

Name _____ Relation to client _____
Custodial ☐ Yes ☐ No ☐ Shared *please explain arrangement* _____
Responsible Party for Billing ☐ Yes ☐ No
If financially responsibility is split with another party, please explain arrangement _____
Mobile Phone _____ Home Phone _____ Work Phone _____
Mailing address _____ City _____ St _____ Zip _____
What information may we share with this contact?
☐ Scheduling Information ☐ Diagnosis ☐ Substance Abuse Notes
☐ Billing Information ☐ Session Notes ☐ Psychological Evaluation

Minor Client Name _____ DOB _____

PARENT/GUARDIAN INFORMATION & PERMISSIONS CONTINUED

Parent/Guardian 3

Name _____ Relation to client _____

Custodial ☐ Yes ☐ No ☐ Shared *please explain arrangement* _____

Responsible Party for Billing ☐ Yes ☐ No

If financially responsibility is split with another party, please explain arrangement _____

Mobile Phone _____ Home Phone _____ Work Phone _____

Mailing address _____ City _____ St _____ Zip _____

What information may we share with this contact?

☐ Scheduling Information

☐ Diagnosis

☐ Substance Abuse Notes

☐ Billing Information

☐ Session Notes

☐ Psychological Evaluation

Parent/Guardian 4

Name _____ Relation to client _____

Custodial ☐ Yes ☐ No ☐ Shared *please explain arrangement* _____

Responsible Party for Billing ☐ Yes ☐ No

If financially responsibility is split with another party, please explain arrangement _____

Mobile Phone _____ Home Phone _____ Work Phone _____

Mailing address _____ City _____ St _____ Zip _____

What information may we share with this contact?

☐ Scheduling Information

☐ Diagnosis

☐ Substance Abuse Notes

☐ Billing Information

☐ Session Notes

☐ Psychological Evaluation

CONTACTS OTHER THAN PARENT/GUARDIAN

Name _____ Relation to client _____

Contact Type ☐ PCP ☐ Emergency Contact ☐ Guardian ☐ Responsible Party for Billing

Mobile Phone _____ Home Phone _____ Work Phone _____

What information may we share with this contact?

☐ Scheduling Information

☐ Diagnosis

☐ Substance Abuse Notes

☐ Billing Information

☐ Session Notes

☐ Psychological Evaluation

Name _____ Relation to client _____

Contact Type ☐ PCP ☐ Emergency Contact ☐ Guardian ☐ Responsible Party for Billing

Mobile Phone _____ Home Phone _____ Work Phone _____

What information may we share with this contact?

☐ Scheduling Information

☐ Diagnosis

☐ Substance Abuse Notes

☐ Billing Information

☐ Session Notes

☐ Psychological Evaluation

PRIMARY CARE PROVIDER

Primary care provider _____ Organization _____

Phone _____ Would you like us to give feedback or consult with them? ☐ Yes ☐ No

Minor Client Name _____ DOB _____

INSURANCE INFORMATION

SPEAK LIFE is a preferred provider for **Blue Cross Blue Shield, Meritain Health, and Medicaid**. If you have insurance other than these, you must check with your insurance to determine coverage.

Note: Co-pays and deductibles are your responsibility.

Primary Insurance Company _____

Insured Party _____ Relation to Client _____

Member ID _____ Insured Party's Information:

Policy Group _____ Birth Sex _____ DOB _____

Employer/School (As indicated on card) _____ Address _____

_____ City/St/Zip _____

Plan Name _____ Phone Number _____

Secondary Insurance Company _____

Insured Party _____ Relation to Client _____

Member ID _____ Insured Party's Information:

Policy Group _____ Birth Sex _____ DOB _____

Employer/School (As indicated on card) _____ Address _____

_____ City/St/Zip _____

Plan Name _____ Phone Number _____

INSURANCE AND PAYMENT

Please initial and sign

_____ I authorize and direct SPEAK LIFE to submit Charges to any and all Payers including, without limit, the health benefit plan. I understand that I remain personally responsible for my Charges. Consistent with law or contract, I agree to pay the full amount of the Charges to SPEAK LIFE upon its demand.

Minor Client name (please print) _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Client (please print)

Parent/Guardian signature _____ Date ____ / ____ / ____

Minor Client Full Name _____ DOB _____

OFFICE POLICY STATEMENT

SPEAK LIFE prohibits the use of any tobacco products, drugs, or alcohol on its property or in the building. Weapons are not allowed on the property or in the building. All staff, clients, and visitors are expected to comply with this expectation. Signs indicating this policy are prominently displayed throughout the agency.

For clients who are 17 years and under, we require either: a parent or guardian to be present in the SPEAK LIFE office building for the duration of the session, (or, by permission 16–17-year-old clients, on their own recognizance, with a prior written consent for authorization signed by parent/guardian for alternative arrangements).

We ask that you do not come to any appointment under the influence of substances.

Pregnant women, women with children, and IV drug users are given priority in drug and alcohol treatment.

Emergency or “on call” assistance is limited in this private practice. The 24-hour answering machine will establish contact between the hours of 8:00 a.m. and 10:00 p.m. If, during the course of treatment, the problems seem too big, the signature on this statement is an agreement that every effort will be made on your part to contact your therapist. If you are unable to reach your therapist, contact your physician or the nearest emergency room at a local hospital and explain the situation. Your therapist will work in conjunction with your physician. It is recommended that you have communicable disease screening with your primary care physician if you have been placed at risk due to illegal chemical use and abuse or if you have been exposed to unsafe sex. IV drug users are at risk for STDs and are referred to local clinics for screening of risks.

Cancellations with at least 24-hour advance notice will be accepted, please make arrangements to reschedule at the earliest opportunity. For cancellations with less than 24-hour notice, a late cancellation fee will be charged of \$75.00.

Payment for services is expected at the time service is rendered. A complete statement of services and credential information is provided for you.

***Please read the above-listed Office Policy Statement, and provide agreement on the following page (page 5)**

Please read and initial the following, in agreement to the Office Policy Statement (listed on page 4):

- _____ A late payment (bill 30-days overdue) will be assessed an extra \$10 charge per month. If the account is referred to a collection agency or attorney, the undersigned agrees to pay all reasonable fees, costs, and collection expenses.
- _____ I give permission for my insurance to be billed and insurance payment to be submitted to SPEAK LIFE.
- _____ I give permission to release necessary information to insurance or to the party making payment.
- _____ By my attendance and my signature, I am consenting to treatment at SPEAK LIFE.
- _____ I understand that the cash discount pertains only if I pay at the time of service.
- _____ I understand that I am responsible for any amount my insurance does not cover.
- _____ I understand that I am responsible for any amount my insurance does not cover.
- _____ I acknowledge that the minor is not currently receiving counseling services with another facility/provider.
- _____ I understand that I may be billed \$25 for phone calls at the discretion of the therapist.
- _____ I have read and received a copy of the Office Policy Statement.
- _____ I have read and fully understand SPEAK LIFE's cancellation policy and will abide by the policy rules.
- _____ **If insurance pays me, I am responsible to submit reimbursement to SPEAK LIFE.**

Minor Client name (please print) _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Client (please print)

Parent/Guardian signature _____ Date ____/____/____