307.426.4204
E-mail: speaklife@speaklife.family
1816 E. 17th St
Cheyenne, WY 82001

SPEAK LIFE
Renewing minds. Healing hearts.

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_____

Gender Identity_____

Sexual Orientation_____

Marital Status ◉ Married ○ Single ○ Other

◉ Employed ○ Unemployed/Other

◉ Full-Time Student ○ Part-Time Student

Race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ 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
- ☐ Billing Information
- ☐ Diagnosis
- ☐ Session Notes
- ☐ Substance Abuse 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
- ☐ Billing Information
- ☐ Diagnosis
- ☐ Session Notes
- ☐ Substance Abuse 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____/____/____

Forms will be signed at Intake Session.

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.

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 within 24-hour advance notice will be accepted, please make arrangements to reschedule at the earliest opportunity. Late cancellations will be charged the therapy rate.

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

Please read and initial the following:

_____ **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 to clear coverage with my insurance.**

_____ **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_____/_____/_____

Forms will be signed at Intake Session.