Insight and Empowerment, LLC
1908 Jennie Lee Drive, Idaho Falls, ID 83404
(208) 932-7048 phone
(208) 970-6188 fax
Insightandempowerment@outlook.com

Clients Name: ____________________________________DOB________________
Address____
City: ______________________State: __________________Zip code: __________
Phone Number: ________________Alternate Number: _______________________
Social Security: _________________________________
Age: ______________________________Gender: __________________________
Employer: ______________________Time at current employment: _____________

Responsible Party Name: ___________________________DOB________________
Relationship to child: ____
Primary Guardian's phone number: _______________________________________

Responsible Party Name: ___________________________DOB________________
Relationship to child: ____
Secondary Guardian's phone number: _____________________________________
Address (if different): ____

Insurance: Primary
Name of Insurance Company:____
Name of Insured: _____________________DOB: __________________________
SS: ________________________ Employer: ____________________________
Relationship to the client: Self Child Spouse Guardian Other
Address: ______________________
State: _________________________ Zip code: _____________________________

Does the client have addi
Secondary Insurance
Name of Insured: ___________________________DOB: ___________________
SS: ______________________________Employer: _______________________
Relationship to the client: Self Child Spouse Guardian Other
Address: ________________________________ City: ______________________
State: ____________________________ Zip code: _________________________

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Financial Policy
Insight and Empowerment accepts most major insurance companies, Optum Medicaid and self-pay clients. Our standard self-pay rates are $60 for thirty minutes, $90 for forty-five minutes and $110 for one hour and $172.50 for a comprehensive assessment. Intern Self-Pay rates are 50% of the typical standard rates.

Payments are due at the time of service. We bill most major insurance companies as a courtesy and at no cost to you. If insurance is billed, payment of outstanding balance is expected within 30 days. New insurance and changes in insurance must be reported to Insight and Empowerment, LLC at the time of service. If changes in information are not reported, the client will be charged a 30.00 reprocessing fee. It is your responsibility to know if a provider in our agency is in network with your insurance plan. We are not responsible for determining whether our providers are in network with your plan. Payments are due at minimum once per month and will be due by the 5th of the month. Co-payments are expected at time of service. There will be a 20.00 charge on all returned checks.

Counseling Services will be suspended if an agreed upon payment has not been made and the client's balance is over 200.00. Payment agreement forms may be requested. Accounts may be assigned to an outside collection agency if the client balance remains and Insight and Empowerment, LLC is unable to receive payments. If collection attempts are made on your behalf, you will be charged a 33.33% collection fee, reasonable attorney fees and court costs, in the event your account is assigned to a collection agency. Clients will be required to pay all attorney fees that accumulate if court proceedings are necessary. A 3.5% processing fee will be charged for all credit card payments at time of payment.

I, ______________________, understand that I am fully responsible for all charges regardless of insurance coverage and payments to satisfy required therapy costs.

I authorize Insight and Empowerment, LLC to receive insurance payments and release any medical records to my health insurance company that are deemed necessary for claims processing.

Responsible Party Signature: ______________________________Date: _________________

Responsible Party Signature: ______________________________Date: _________________

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Recurring Card Payment Authorization

You authorize regularly scheduled charges to your credit card. You will be charged the amount indicated below following each session. A receipt for each payment will be provided to you at your request and the charge will appear on your credit card statement. You agree that no prior-authorization will be provided unless the amount changes, in which case you will receive notice from us prior to the charge occurring.

I ____________________________________ authorize Insight and Empowerment, LLC to charge my credit card indicated below for $__________and the 3.5% processing fee following each session, for ______________________________.

Billing Information
Billing Address: ____________________________________ Phone: ________________________
City, State, Zip: ____________________________________ Email: _________________________

Card Details
___Visa ___ Mastercard ___ Discover ___ American Express

Cardholder Name: ____
Account Number (CC): ____
Expiration Date: ______________
CVV: _______________________
Zip Code: ____________________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Insight and Empowerment, LLC immediately for changes that need to be made to the card on file or to terminate this authorization. This authorization only applies to self-pay clients, or co-pays and co-insurances, or when meeting the deductible. This does not apply to late cancellation fee's or no-show fee's that may also need to be charged.

Cardholder Signature: ________________________________ Date: ________________________

Termination of Authorization:

I am terminating my authorization for automatic credit card processing to Insight and Empowerment, LLC for the following reason:
____

Date: ____________________

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Informed Consent

Hours of Operation:
Insight and Empowerment is generally available for appointments from the hours of 9am – 6pm Monday through Thursday and 9am – 5pm on Friday's. Individual clinician's hours may vary from this time. If there is an emergency, please let us know and we will accommodate those needs on an emergent basis.

Assessments and Appointments:
Insight and Empowerment will gather any demographic and insurance information when a client calls to schedule an appointment. An intake packet will either be emailed to the client, or the client can pick up the intake paperwork at Insight and Empowerment, LLC to have ready for the first appointment. If the client fails to have necessary forms ready to complete the Comprehensive Diagnostic Assessment, they will be asked to reschedule the appointment. A Comprehensive Diagnostic Assessment will be required for all patients and is expected to take approximately 1 hour in session. Each additional therapy session is expected to take approximately 45 minutes unless otherwise stated by the clinician.

Confidentiality:
All information that is discussed in session at Insight and Empowerment, LLC will be kept confidential unless the client has given written permission to disclose information to another party. Consent to release information will be attached to the client's file. Mandatory reporting requirements will be followed by clinicians and information pertaining to 1) threat of harm to self and/or others, 2) suspected abuse or neglect of a child or elder, 3) or suicidal/homicidal ideations with a plan, or 4) court ordered information. In this case, the clinician will contact the appropriate individuals and/or authorities to meet state requirements.

Minors Over the Age of 14:
Idaho law prohibits the release of confidential statements made by clients over the age of 14 without their written consent unless such information is necessary to obtain insurance coverage, carry out the treatment plan, prevent harm to the child or others, or as authorized by court order. The minor also has the right to access treatment information unless that information would be damaging to the client.

All personal information will be kept within the walls of Insight and Empowerment, LLC and out of sight from other clients and/or persons. Exceptions to the confidentiality agreement will include coordinating care with medical providers if the client allows this and signs a release of information to this effect. In the case that insurance companies require clinical summaries, Insight and Empowerment will provide them with this information in order to continue

participating in network with said company. Insurance claims will have the diagnoses code as well as the code for the type of services that have been rendered. Insight and Empowerment, LLC will not speak about your attendance or care at our agency with anyone other than the responsible party that has completed the intake information, other than if there are court documents stating that another parent has legal custody of the child.

Non-compliance and/or Cancellations:
If the client needs to cancel an appointment, we ask that the client give Insight and Empowerment, LLC a 24-hour notice when possible. If the client calls the same day of the appointment to cancel, the therapist may charge a late cancellation fee up to 50.00. If the client no shows an appointment, the therapist may charge a no-show fee of up to 50.00. Following three no-show appointments, the client will be discharged from the agency. We kindly ask that if another obligation comes up causing you to cancel your appointment, to contact us immediately at (208) 932-7048. Likewise, if a client has been attending therapy sessions and the therapist deems the sessions to be ineffective based on non-compliance, we will ask that services be discontinued immediately.

Emergencies:
Insight and Empowerment, LLC provides an after-hours crisis line for emergencies, by calling 208-360-2964 where a clinician will be available. The crisis line is co-facilitated with Wright Step Counseling and Recovery, LLC with a business associates' agreement in place. The client may also contact, Behavioral Health Crisis Center of East Idaho at 208-522-0727, Eastern Idaho Medical Center at (208) 529-6111 or Region VII Mental Health at (208) 528-5700 or go to the nearest emergency room.

Treatment:
Services provided will be from evidenced based therapeutic models and the clinicians will allow the client time for questions and/or feedback regarding frequency, intensity, and duration of treatment recommended based on diagnoses. There is no guarantee that the services provided will decrease the symptoms that are being presented. Therapy sessions will include individual and group therapy. Risks associated may include an increase in symptoms, and possible recommendations for medication review and management at another location. It is our goal to assist you in gaining insight into your mental health and/or substance use needs as well as provide skills to decrease symptoms and improve your condition. Services may be modified based on insurance caps and/or policies. Billing is provided at no additional cost to our clients unless as noted prior, the insurance information has changed, and this was not disclosed by the client (see financial policy).

By signing this consent, I agree that I have read and agree to the information listed above. I also understand that I have the right to withdraw my consent at any time.

Responsible Party Signature: ______________________________Date: ___________

Responsible Party Signature: ______________________________Date: ___________

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Clients Rights, Responsibilities

Rights

- Client has the right to receive information about services provided, network practitioners and member's rights and responsibilities.
- Client has the right to be treated with respect and recognition of his or her dignity and right to privacy.
- Client has the right to participate with network practitioners in making decisions about his or her healthcare. (Provider disputes should not interfere with the professional relationship between you and the member).
- Client has a right to a candid discussion of appropriate or medically necessary treatment options for his or her condition.
- Client has the right to voice complaints or appeals to Insight and Empowerment, LLC and/or the insurance provider.
- Client has the right to make recommendations regarding member' rights and responsibilities policies.
- Client has a right to care that is considerate and that respects his or her personal values and belief system.
- Client has a right to Personal Privacy and Confidentiality of information.
- Client has a right to reasonable access to care regardless of race, religion, gender, sexual orientation, ethnicity, age or disability.
- Client has a right to have family members participate in treatment planning. Members over 12 years old have the right to participate in such planning.
- Client has a right to individualized treatment, including adequate and humane services regardless of the source(s) of financial support, receive provision for services within the least restrictive environment possible, an individualized treatment or program plan, periodic review of the treatment or program plan, an adequate number of competent, qualified and experienced professional clinicians to supervise and carry out the treatment plan.
- Client has a right to participate in the consideration of ethical issues that may arise in the provision of care and services including: resolving conflict, withholding resuscitative services, forgoing or withdrawing life-sustaining treatment, participating in investigational studies or clinical trials.
- Client has a right to designate a surrogate decision-maker if he or she is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.
- Client has a right to be informed, along with his or her family, of his her or her rights in a language they understand.
- Client has a right to be informed of rules and regulations concerning his or her own conduct.

- Client has the right to choose not to comply with recommended care, treatment, or procedures and be informed of the potential consequences of not complying with the treatment recommendations.
- Client has the right to be informed of the reason for any non-coverage determination, including the specific criteria or benefit provisions used in the determination.
- Client has the right to have decisions about the management of their behavioral health benefits made based on appropriateness of care.
- Client has a right to inspect and copy their protected health information (PHI) and in addition, request to amend their PHI, request an accounting of non-routine disclosures of PHI, request limitations on the use or disclosure of PHI, request confidential communications of PHI to be sent to an alternate address or by alternate means, make a complaint regarding use or disclosure of PHI, receive a Privacy Notice.
- Client has a right to receive information about the network's clinical guidelines and quality assurance and performance Improvement program (QAPI).

Responsibilities

- Client will be responsible for supplying information needed to provide care.
- Client will be responsible to follow plans and instructions for care that they have agreed on with his or her network practitioner.
- Client will be responsible to understand his or her health programs and participate in developing mutually agreed upon treatment goals to the degree possible.
- Client will be responsible to keep their scheduled appointments and actively participate in treatment.

Grievances:

- In the event a client feels like their treatment at Insight and Empowerment, LLC is unfair or inappropriate, they will be asked to contact the owner, Sarah Hernandez, LCSW at (208) 932-7048 to discuss their concern. Client will be asked if they wish to write a formal grievance.

- Formal Grievances will be submitted to the insurance company within 14 days. The insurance company may further investigate the complaint. A corrective Action Plan may result from the complaint. A written response will be given to the client and kept in his/her file for a minimum of 2 years.

I acknowledge the rights, responsibilities, and grievance procedures written by Insight and Empowerment, LLC. I understand that if I have any further questions, I am encouraged to ask a professional at the agency for further explanation.

Responsible Party Signature: ______________________________Date: ___________

Responsible Party Signature: ______________________________Date: ___________

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HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.
Uses and disclosure of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you or may be provided to a physician to whom you have ben referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may also call you by name in the waiting room when your clinician is ready to see you. We may disclose your protected health information, as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situation include: as By Law, Public Health issues are required by law, Communicable situation include: as Required Abuse Or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ

Donation: Research: Criminal Activity: Military Activity and Nation Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we much make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other permitted and Required Uses and Disclosures will be made only with your consent, authorization or Opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. However, under Federal Law, you may not inspect or copy the following record: psychotherapy notes: information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action/proceeding. You may not inspect your protected health information that is subject to law that prohibits access to protected health information.
You may request a copy of your medical record by appearing at the office in person or calling our office at 208-932-7048. With a signed consent for us to disclose your medical records, electronic transmissions of your medical record may be sent to another provider at no cost.

You have the right to request a restriction of your protect health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information may not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. In the event the provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional. Records will be sent to your new provider at no cost, once a signed consent to disclose records is received.

You have the right to request to receive confidential communications from us by alternative means. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
You may have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against your for filing a complaint.

- U.S. Department of Health and Human Services
  200 Independence Avenue, S.W.
  Room 509F HHH Bldg.
  Washington, D.C. 20201

- Email to OCRComplaint@hhs.gov

  Filing a Complaint | HHS.gov

This notice was published and becomes effective on/or before February 1, 2022. You have the right to discuss the contents of this notice.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Office, Sarah Hernandez, LCSW, in person or by phone at our mail phone number.

You can also reach her via email at Insightandempowerment@outlook.com We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. Signature below is only an acknowledgment you have received this notice.

Responsible Party Signature: ______________________________Date: ___________

Responsible Party Signature: ______________________________Date: ___________

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Electronic Private Health Information ePHI Communication

Client's may request communication through email and/or text messages regarding scheduling or for administrative functions at Insight and Empowerment, LLC. We would like you to be aware that there may be various privacy risks associated with this form of communication. This is also up to the discretion of the professional counselor whether to utilize this form of communication. E-mails and text messages will become part of your mental health records at the agency. Security safeguards are put in place in accordance with HIPPA practices.

Standard emails are not secure and pose some risk that data can be intercepted if the wrong email address is accidently used. There is no assurance of the confidentiality of either of these two communication methods. The use of electronic communications may increase the risk of unauthorized disclosure of and/or access to ePHI. When inappropriate access has occurred, Insight and Empowerment, LLC has an obligation to inform the patient of a breach in privacy.

It is our policy to respond to emails within 24 business hours. Should you wish to request an appointment or telephone call sooner, please contact the office at 208-932-7048.

If you are fully aware of these and other potential risks and still would like to have communication through email and/or text, please sign below: "I agree to not hold Insight and Empowerment, LLC responsible for unauthorized disclosure of and/or access to ePHI that was obtained accidentally through these methods. By signing below, you are also certifying that the email address and phone number provided on this request is accurate, and that you accept full responsibility for messages sent to and from this email address and/or phone number.

Email only ______ Text only _____ Email and Text ______ None ______

E-Mail Address: ____

Responsible Party Signature: ______________________________Date: _________________

Responsible Party Signature: ______________________________Date: _________________

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Release of Protected Health Information

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your health information for the purposes described below unless there is a serious or imminent threat to the health and safety of you or to others. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed.

Individual Information (For Person whose Information will be shared)

Name: ________________________________ Date of Birth: _____________________

Address: ____
City: State: Zip:
Telephone Number: _____________________

I authorize that I am the individual or the individual's legal representative__________________________________ (DOB) _____________ and authorize Insight and Empowerment, LLC to share, give, and receive health information with the following individuals and/or agencies:

Name/Agency: ____
Address: ____
Phone: ________________________________FAX____________________________
This information will be limited to: (please initial)
___ Physical or Medical Records
___ Scheduling
___ Comprehensive Diagnostic Assessment
___ Entire Treatment Record (except notes)
___ Appointment Times
___ Other: ____

Name/Agency: ____
Address: ____
Phone: ________________________________FAX____________________________
This information will be limited to: (please initial)
___ Physical or Medical Records
___ Scheduling

___ Comprehensive Diagnostic Assessment
___ Entire Treatment Record (except notes)
___ Appointment Times
___ Other: ____

Name/Agency: ____
Address: ____
Phone: ______________________________FAX__________________________

This information will be limited to: (please initial)
___ Physical or Medical Records
___ Scheduling
___ Comprehensive Diagnostic Assessment
___ Entire Treatment Record (except notes)
___ Appointment Times
___ Other: ____

I understand that my records are protected under Federal Regulations governing Confidentiality of Protected Health Information (PHI) under HIPPA and Confidentiality (42 CFR part 2).

I understand I have the right to change or revoke this authorization at any time. This authorization will automatically expire within 12 months from the date of signature. A photocopy of this form will be considered as valid as the original. You may rescind this authorization at any time.

I understand that if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to Insight and Empowerment, LLC.

____
Signature of Individual or Legal Representative:

____
Printed Name of Individual or Legal Representative:
Date______________________________

____
Signature of Minor (age 14+)

____
Printed Name of Minor
Date______________________________

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Consent for Tele-Health Services

Client Name: ______________________________ **Date: _______________________**
Email address: _____________________________ **Phone:______________________**

I understand and agree to the following with respect to medical/mental health services:

- My provider uses a secure, HIPPA and HITECH compliant video telehealth platform known as Zoom, Doxy.Me or Psychology Today for Telehealth. I will need internet access, using a computer, tablet or smart phone (larger screens are generally better). If none of these are available to me, or if technical problems interfere with video communication, telehealth services may be conducted by telephone in certain situations. I have discussed the risks, benefits, and specific application to my treatment of each of these technologies with my provider. It is up to the provider to determine if these services are clinically appropriate.

Privacy and confidentiality are shared responsibilities of the provider and the client. It is my responsibility to maintain privacy on the client end of communication. I agree to use reasonable security protocols to protect the privacy of my own health care information. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

I agree not to record video or audio sessions without my provider's consent. Making recordings can quickly and easily compromise my privacy and should be done only with great care. My provider will not record video or audio sessions, unless otherwise consented to and agreed upon.

The laws that protect the confidentiality of my medical information also apply to telehealth services. As such, the information disclosed by me in the course of mental health services is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards self or an identifiable victim; and defending claims brought by the client against the provider.

There are risks and consequences from telehealth services, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons: and/or the electronic storage of my medical intonation could be accessed by unauthorized persons. These risks are offset by my provider's use of HIPAA/HITECH compliant service which is encrypted for video telehealth communications, and HIPAA/HITECH compliant Electronic Health Records systems. Further, the contents of my provider's computer are encrypted.

In addition, I understand that telehealth services and care may not yield the same results nor be as effective as face to-face service. I understand that if my provider believes I would be better served by another form of psychotherapeutic service (e.g. in-person), I will be referred to a provider in my area who

can provide such service. My provider and I will regularly reassess the appropriateness of continuing to deliver services to me using the technologies we have agreed upon today, and modify our plan as needed.

I understand that it is my responsibility to check with my insurance plan to determine coverage of telehealth services.

I have the right to be a participant in treatment decisions, to seek a second opinion, to file a complaint without retribution, and to refuse treatment, without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means, including telephone or secure email. I understand that SMS text messaging (e.g., through my cellular carrier) and nonencrypted email are not secure and should not be used to convey protected health information. All textual messages I exchange with my provider (e.g. emails and text messages) will become a part of my health record.

As a recipient of telehealth services, I will need to participate in ensuring my safety during mental health crises, medical emergencies, and sessions that I have with my provider. I agree to designate an emergency contact person, with whom my provider will be permitted to communicate about my care during emergencies. I understand that I can withdraw that permission at any time, but this will mean my provider will be unable to continue telehealth services at that time.

I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a telehealth consultation. Instead, I agree to seek care immediately through my own local health care provider or at the nearest hospital emergency department or by calling 911.

I hereby acknowledge that my questions have been answered to my satisfaction, and that I understand and agree to all of the above. I give my permission to Insight and Empowerment, LLC to provide me with psychotherapy, counseling, family counseling, and any other mental health treatment services deemed medically necessary, via telehealth, as described above.

This form may be signed by the client/responsible party and return via fax, email, or mail.

Client's Signature: ____
Date: __________________________

Parent/Guardian Signature:_________________________________
Date: _________________________