

Adolescent Client Information Form

Name: Last _____ First _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Parent Contact: _____

Email: _____ *Please note if it is not okay to contact you via any of these methods*

Birth Date: _____ Social Security # _____ Sex: M _____ F _____

Payment for Services Information

Check here for **private payment** without insurance _____ at a rate of _____ per session

Insured's Employer's Name: _____ **Address:** _____

Primary Insurance: _____ Policy Number: _____

Name of Insured and relationship to client: _____ **Group Number:** _____

Address of Insurance Company: _____ Phone: _____

Secondary Insurance: _____ Policy Number: _____

Name of Insured and relationship to client: _____ **Group Number:** _____

Address of Insurance Company: _____ Phone: _____

Consent to Treatment

I acknowledge that I have reviewed and understand my rights in the therapeutic relationship as described in the document "Client Information" and have been given the opportunity to ask any questions regarding this process. I consent for my dependent to take part in the treatment by Julie Luzarraga, LCSW. I understand that the practice of medicine is not an exact science and I acknowledge that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time. I understand that I am financially responsible for my treatment as the patient, guardian, conservator or insured for all charges not covered by the above assignments. **Charges may include medical insurance deductibles, co-insurance or out-of-pocket expenses. I understand that I must call to cancel an appointment at least 24 hours before the time of the appointment. I understand that I am responsible for a \$60 charge for no-shows and a \$45 charge for canceling within 24 hours of a scheduled appointment.** I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), and providers of any services or treatment I receive. However, I understand that I am responsible for the payment of services. I understand that if payment for the services I receive is not made the therapist may stop my treatment. I have been given a copy of Julie Luzarraga's Notice of Privacy Practices for Protected Health Information ("Notice of Privacy Practices"). I understand that Julie Luzarraga has the right to change the Notice of Privacy Practices at any time. I may obtain a current copy of the Notice of Privacy Practices at 8021 Chicago Street, Omaha, NE 68114. The undersigned does hereby acknowledge receipt of the Notice of Privacy Practices. The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, or is duly authorized to execute the above and accept its terms.

Patient's Signature/ Guardian	Date
Responsible Party's Relationship to Patient	Insured's Signature
Witness to Signatures	Patient Unable to Sign Consent Because

Referral Information

Who referred you: _____

Reason for referral: _____ May I thank him or her? _____

Household & School Information

Mother (Name & DOB): _____

Father (Name & DOB): _____

Parents are _____ Divorced _____ Married _____ Separated

Guardians (if other than parents): _____

Please list the names, relationship to and ages of who your child lives with: _____

School: _____ Grade: _____

Medical Information

Please list any medical problems: _____

Please list any medications your child is taking: _____

Emergency Contact Information (Name and telephone number): _____

Other Providers Involved in Your Child's Care:

<u>Provider's Name</u>	<u>Address</u>	<u>Phone</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Therapist Use only
Dx Code (To be entered by therapist): _____

