

Prime Behavioral Health, LLC

CHILD/ADOLESCENT INTAKE PACKET

Counselor: _____

CLIENT INFORMATION

Client Name _____

Street Address _____ PO Box _____

City/State/Zip _____

Home Phone # _____ **May we call or leave a message at this number?** Yes No

Daytime Phone # _____ **Can we contact you here and leave a message?** Yes No

Cell Phone # _____ **May we call or leave a message on this phone?** Yes No

Client Date of Birth _____ Age: _____ Social Security # _____

Parent/Responsible Party Name (if client is minor) _____

Parent/Responsible Party Social Security # _____ Date of Birth _____

Primary Care Physician & Phone#: _____

Emergency Contact Name (required): _____ **Phone #:** _____

Address (required): _____

Insurance Information (Copy of Insurance Card and ID is Required)

• **This section is required to be filled out in full •**

1) **Primary** Insurance Company _____ Ins Co Phone # _____

Employer of Subscriber _____

Name of Subscriber _____ Date of Birth _____

Subscribers Social Security # _____ Relationship to Client _____

Address of Subscriber (if different from Client) _____

2) **Secondary** Insurance Company _____ Ins. Co Phone # _____

Employer Name _____

Name of Subscriber _____ Date of Birth _____

Subscribers Social Security # _____ Relationship to Client _____

Address of Subscriber (if different from Client) _____

IF THERE IS A THIRD INS. PLEASE NOTIFY RECEPTIONIST TO GIVE YOU ATTACHMENT

CLIENT/ RESPONSIBLE PARTY AGREEMENT

The above information is current and correct to the best of my knowledge.

I understand my insurance coverage as noted above and that I am responsible for paying the co-pay, if required, and/or the amount not covered by my insurance policy. This agreement also grants authorization to PBH to release such information as may be necessary for completion of my insurance claim with payment of benefits to PBH for services rendered.

Responsible Party Name (please print) _____

Responsible Party Signature _____

Date _____

Witness _____

Date _____

Revised 10/15

Instructions: To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to the child, leave them blank.

Information supplied by: _____ Relationship: _____ Today's Date: _____

Identifying Information

Child's Name: _____ **Date of Birth:** _____ **Age:** _____
Gender: Male Female **Race:** _____ **Height:** _____ **Weight:** _____
Hair Color: _____ **Eye Color:** _____

Behavioral Health

Why is the child coming to counseling?

What issues or circumstances do you believe contribute to the child's problems?

How long has this problem persisted? _____

Under what conditions do the problems usually get worse?

Under what conditions do the problems usually improve?

Has the child previously been involved in counseling? No Yes **If yes, describe the reasons for counseling, who provided the counseling and what was the outcome.**

Counselor _____

Reason:

Outcome:

List your child's greatest strengths:

List your child's greatest weaknesses:

List your child's main difficulties at home:

List your child's main difficulties at school:

Psychiatric Hospitalizations: None Past Recent

Dates of Service:	# of Days	Where & Reason (suicidal, depressed etc.)
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Dates of Service:	# of Days	Where & Reason (suicidal, depressed etc.)
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Behavioral Health Symptom Checklist

Please indicate the degree your child has experienced any of the following symptoms in the last 4 weeks.

0 = Never

1 = Occasionally

2 = Regularly

3 = Frequently

- _____ 1. Trembling, or feeling shaky
- _____ 2. Shortness of breath or smothering sensation
- _____ 3. Racing heart, heart palpitations or chest pain (circle which)
- _____ 4. Moist palms or excessive sweating
- _____ 5. Dizziness, lightheadedness, unsteady or faint (circle which)
- _____ 6. Nausea, diarrhea, or other abdominal distress (circle which)
- _____ 7. Frequent headaches or other muscle aches
- _____ 8. Startle easily
- _____ 9. Irritability (loses temper easily)
- _____ 10. Worrying a lot
- _____ 11. Trouble swallowing, "lump in throat", or choking sensation
- _____ 12. Fearful of or embarrassed by being watched or being the focus of attention
- _____ 13. Avoid talking to strangers
- _____ 14. Fear of embarrassment
- _____ 15. Persistent fear of an object (snakes) or situation (high places) considered excessive or unreasonable
- _____ 16. High levels of anxiety in the presence of an object or situation
- _____ 17. Regular and disturbing thoughts about a past traumatic experience
- _____ 18. Regular and disturbing dreams about a past traumatic experience
- _____ 19. Avoidance of thoughts feelings, or conversations associated with a traumatic experience
- _____ 20. Excessive hand washing or fear of germs
- _____ 21. Excessive checking (i.e., doors, locks, stove)
- _____ 22. Excessive need for order or neatness or counting ritual(s)
- _____ 23. Unusual and persistent sad feelings
- _____ 24. Diminished interest or participation in enjoyable or important activities
- _____ 25. Difficulty concentrating or poor memory (circle which)
- _____ 26. Tire easily or low energy level
- _____ 27. Thoughts of suicide
- _____ 28. Increased or decreased sleep (circle which): avg. hrs per night _____
- _____ 29. Feelings of hopelessness
- _____ 30. Persistent and abnormally elevated mood
- _____ 31. Over inflated feelings of self-worth
- _____ 32. Decreased need for sleep
- _____ 33. Rapid or racing thoughts
- _____ 34. Excessive involvement in pleasurable activities
- _____ 35. Excessive and/or reckless spending
- _____ 36. See or hear things that others around you are unable to perceive
- _____ 37. Hold ideas or beliefs that are not shared by others
- _____ 38. Self induced vomiting
- _____ 39. Excessive exercise
- _____ 40. Use of laxatives or diuretics to lose weight
- _____ 41. Dieting (very strict, women consuming less than 1400 daily calories or men less than 2000 calories)
- _____ 42. Careless mistakes in school work, work, or other activities
- _____ 43. Can only pay attention for short periods at school/work/home
- _____ 44. Failure to complete schoolwork, chores, duties
- _____ 45. Hyperactive: fidgets, squirms, talks excessively
- _____ 46. Acts without thinking of consequences

Drug and Alcohol History

Indicate the level of use for each substance by checking the appropriate box.

	No Use	Past use	Current Use		No Use	Past use	Current Use
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If current or past use is indicated to any of the above items compete the following questions?

Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection
Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection
Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection

Has the child ever received inpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Has the child ever received outpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Is the child currently pregnant? No Yes Is the child an IV drug user? No Yes

Family History

Parent's marital status: Married Divorced Separated Never Married Widowed

If the parents are not married, the child's age when divorce, separation or parents death occurred? _____

What is the relationship between the child and his/her custodial parent(s) Check all that apply:

- Parents married, together Single Parent, Mother Single Parent Father Parents Unmarried
 Mother & Stepfather Father & Stepmother Adoptive Family
 Other _____

Living Situation: Parent's Home Foster Home Relative's Home Homeless Group Home
 Residential Other _____

Household member's names (if client lives in more than one household list household 1 – 2)	Relation to the Client	Age	Race	Occupation or School	Level of Education
Significant Family Members/Others not listed above:	Relation to the Client	Age	Race	Occupation or School	Level of Education

Mother's age: _____ If deceased, how old was the child when she passed away? _____

Father's age: _____ If deceased, how old was the child when he passed away? _____

Number of Brothers _____ Their ages: _____

Number of Sisters _____ Their ages: _____

Where is the child in birth order (i.e. 1st born, 2nd born etc.) of his/her siblings? _____

Briefly describe the child's relationship with his/her siblings.

Briefly describe the style of parenting (including types of discipline) used in the household.

Describe the reasons your child is disciplined.

Parent's Employment

Mother's Current Employment Status Employed Unemployed Job/Occupation: _____

Name of employer: _____ Date Last Worked _____ Satisfied with Job Yes No

Father's Current Employment Status Employed Unemployed Job/Occupation: _____

Name of employer: _____ Date Last Worked _____ Satisfied with Job Yes No

Family Financial History:

Amount of Monthly Income _____ Source(s) of income: _____

Loss of Income due to: _____

Financial Problems No Yes If yes, explain: _____

Developmental History

List any drugs/medications used by the mother or family at the time of conception or by the mother during pregnancy

Indicate important physical development issues including developmental milestones including sensory/motor, motor, cognitive, mental retardation or autism

List the ages when the following developmental milestones occurred:

	<u>Age</u>	<u>Comments</u>
Walking	_____	_____
Talking	_____	_____
Toilet Trained	_____	_____

Rate your child's development, compared to others the same age in the following areas

Social Development	<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average
Physical Development	<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average
Language	<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average
Intellectual Ability	<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average
Emotional Expression	<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average

For each type of development that you rated as *Below Average*, describe your current *Specific* areas of concern.

Medical History

Physician Name: _____

Address: _____
Street & Number City State Zip

Date of most recent physical exam: _____ **By Whom:** _____ **Phone:** _____

Results: _____

Immunizations Check the immunizations for the following diseases:

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> German Measles	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> Polio	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Tetanus		

Drug Allergies:				*
List any major illness and/or operations				
Has the child had any medical hospitalizations in the last three years <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, complete below:				
Hospital	City	Date	Reason	
List any <i>current</i> physical concerns (e.g. high blood pressure, headaches, dizziness, etc.):				
List any <i>past</i> physical concerns:				
Has the child ever had head trauma that resulted in loss of consciousness and/or required medical treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes				
<i>What medications is client now taking? List all medications including over the counter and herbal therapy, dose (if known), how long taken, and the doctor who prescribed the medication.</i>				
Prescription/Over the Counter Medication: <input type="checkbox"/> No <input type="checkbox"/> Yes		Out of Medication: <input type="checkbox"/> No <input type="checkbox"/> Yes		
Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown		Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown		
Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown		Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown		
Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown		Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown		
Does the client/family think medications help the client get better? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown				
Does your child use caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes from (coffee, tea, soda) _____		Daily Use _____		
Does your child use tobacco? <input type="checkbox"/> No <input type="checkbox"/> Yes from (cigarettes, snuff, snus) _____		Daily Use _____		
On the average, how many hours of sleep does your child receive nightly? _____				
After going to bed, how long does it take your child to fall asleep? _____				
If falling asleep is a problem, how long has it been a problem? _____				
Does your child regularly awaken in the night?				<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child regularly have bad dreams or nightmares?				<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child experience bad dreams and is unable to awaken during them?				<input type="checkbox"/> No <input type="checkbox"/> Yes
Describe your child's appetite? <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Average Appetite <input type="checkbox"/> Large Appetite				
Has the child's weight changed in the last year? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, by how much? _____ <input type="checkbox"/> weight gain <input type="checkbox"/> loss				
Has client had any of the following <u>symptoms</u> in the past 60 days? Please check.				
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Coughing	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Sleep Problems	
<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Breathing Difficulty	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Tingling in Arms/Leg	
<input type="checkbox"/> Confusion	<input type="checkbox"/> Falling	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tremors	
<input type="checkbox"/> Consciousness Loss	<input type="checkbox"/> Gait Unsteadiness	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Vision Changes	
<input type="checkbox"/> Constipation	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Pulse Irregularity	<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Other: _____				

Health History Questionnaire

Has the client or any relatives (related by blood) had any of the following health problems? If a blood relative has had the condition, please write down the relationship to the client (parent, brother, sister, aunt/uncle, cousin, children, etc.) in the comment section.

Problem	Client			Family History	Relationship to the Client
	Now	Past	Never		
AIDS					
Alcoholism					
Anemia					
Anxiety					
Arthritis					
Asthma					
Bipolar Disorder					
Bleeding Disorder					
Brain Tumor					
Cancer					
Cirrhosis					
Depression					
Diabetes					
Drug Abuse					
Epilepsy/Seizures					
Eye Disease					
GI Problems					
Glaucoma					
Headaches					
Head Injury					
Hearing Problems					
Heart Disease					
Hepatitis					
High Blood Pressure					
Hyperactivity					
Jaundice					
Kidney Disease					
Learning Problems					
Lung Disease					
Low Blood Pressure					
Menstrual Pain					
Oral Health/Dental					
Schizophrenia					
Sexually Transmitted Disease					
Speech Problems					
Stroke					
Suicide					
Thyroid					
Tuberculosis					

If the client has had any of the above, please write the problem, what treatment was received, and when

Problem & Treatment received:	When
Problem & Treatment received:	When

CANCELLATIONS & MISSED APPOINTMENTS

All appointment cancellations require a **24-hour notice** or in the case of illness, a message prior to 8:00 am on the appointment day. Our voicemail is available 24 hours/day to take messages after hours or on the weekends if you need to cancel an appointment. Adequate notification respects the doctor/therapist's time as well as allows availability to others requesting services. Failure to not show at all or to give a less than 24-hour notice on cancellations will result in a \$35.00 charge which must be paid prior to scheduling another appointment. In addition, arriving late or leaving early could also result in charges that would be equal to the time you kept your therapist waiting. **Insurance will not be billed for this. ***

Note to Parents – if you are financially responsible (the signer on this form) for your child, it is your responsibility to make sure you know when your child's appointments are, and it is your responsibility to pay this fee if the appointment is missed. Continued non-compliance in keeping your appointments can result in dismissal from the practice.

I HAVE READ THE OFFICE POLICY AND RECEIVED A COPY OR HAD ACCESS TO IT ON THE WEBSITE. I UNDERSTAND AND AGREE TO THE TERMS CONTAINED IN IT.

Responsible Party/Legal Custodian Signature

Date

Witness

Date

**PRIME BEHAVIORAL HEALTH, LLC
CONSENT FOR TREATMENT AND INFORMATION SHEET**

The decision to begin mental health treatment is one that may have important results for your life. Research has shown that individuals entering therapy achieve more favorable results when they have a good understanding of what to expect. We have developed this sheet to provide you with an overview, but no information sheet can answer all questions, so please feel free to ask us about any questions you have.

Individual sessions usually last 45-60 minutes providing us with time to think about what you have said, make notes, and plan your services. Your first session will usually be devoted to assessing the type and extent of the problems and concerns you have and to plan your services.

Your therapist has a responsibility to ask questions about your history, your life situation, and your current distress. Your therapist also has a responsibility to be open with you and to provide direct information about your treatment.

As being the responsible party for a client in our office, you will also have certain responsibilities for payment and for keeping your appointments. Your most important responsibility, however, is to yourself (and your child) – to work towards the goals we mutually set, and to work toward your goals both during sessions and during days between sessions. This is your time for you and your child.

There are charges which are not covered by insurance for missed appointments and late cancellations. Please refer to the Canceled and Missed Appointment Policy form for details on these charges.

Once any charge has remained on your account for 90 days, the entire outstanding balance will be forwarded to a collection agency. Any fees and/or interest added by the collection agency will be charged to you in addition to the outstanding balance which you owe Prime Behavioral Health.

We place a high value on the confidentiality of your records. Records will be held confidential except as required by law, or as released by your written authorization. In a small number of situations, therapists are legally required to reveal information; for example, if you reveal information that indicated a clear danger of injury to yourself, your child, or others. Records may, on occasion, be reviewed for quality and appropriateness of care by the clinic or by your insurance company.

Every effort is made to answer calls during our regular office hours. If we are unable to answer or the office is closed at the time of your call, please leave a message, and we will return your call as soon as we can.

Entering psychotherapy requires a commitment of time, energy and resources, and often also requires some courage to make the first appointment. Your commitment will be honored here and you will be treated with respect. Thank you for choosing our office.

I HAVE READ THE ABOVE AND UNDERSTAND AND AGREE TO MY RESPONSIBILITIES, AND CONSENT FOR TREATMENT.

Responsible Party Signature	Printed Name of Client	Date
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IF CLIENT IS A MINOR, PERSON SIGNING THIS FORM ATTESTS TO HAVING LEGAL CUSTODY AND CONSENTS TO FEES AND TREATMENT BY THIS SIGNATURE.

Parent Signature	Date	Revised 10/15
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COURT FEE SCHEDULE

- All fees charged for court activity are based on portal-to-portal travel.
- A retainer for the estimated full amount of the fee will be required one week before a court appearance.
- If actual fees exceed estimated fees, clients will be responsible for the remainder of the fee within one week of rendered services.
- Fees will be assessed in four-hour blocks.

Fee Rates

- Fees for court related activities requested more than two weeks in advance = \$120 *per hour* (*Minimum = \$480*)
- Fees for court related activities requested less than two weeks in advance = \$240 *per hour* (*Minimum - \$960*)

Cancellation Policy

- If request for court related activities is cancelled 2 weeks prior to scheduled appearance the client will be entitled to a full refund minus an time the counselor used for preparation.
- If request for court related activities is cancelled 1 week prior to scheduled appearance, the client will be entitled to a 50% refund minus any time the counselor used for preparation.
- No refund will be given for cancellations that occur within the week of the scheduled activity.
- If a counselor is subpoenaed for court related activity and the subpoena is cancelled, regardless of retainer not being submitted, the client will be responsible for the initial requested fee.

Consideration for modification of this fee schedule will be made on a case-by-case basis.

Signature of Responsible Party/Legal Guardian

Date

Client name

Your signature states that you are aware of this policy. Please sign even if you feel that this will not apply to your situation.

Prime Behavioral Health
647 Hill Rd. N Ste. B 711 N. Columbus St., Ste., 100
Pickerington, OH 43147 Lancaster, OH 43130
614-833-6900 740-653-6500

FEE SCHEDULE
All Counselors

Initial Session	\$160
Office Visit ~60 Min	\$150
Office Visit ~45 Min	\$120
Office Visit ~30 Min	\$ 80
Family Counseling ~45 Min	\$130

I have read and understand the Financial Policy and office procedures at Prime Behavioral Health, LLC. I agree to the cancellation/reschedule policy. I further understand I will need to make my co-pay at each visit. I acknowledge that I have either received a copy of this policy or have it available to me from the website at www.carebyprime.com .

Client Name (please print)

If the client is a minor, the Guardian must sign below:

Responsible Party/Legal Guardian Name (please print)

Responsible Party/Legal Guardian Signature

Date

Witness

Date

Revised 10/15

Prime Behavioral Health
NOTICE FOR ACCOUNTS WITH BALANCES DUE

Please take note of our policy regarding our scheduling policy due to outstanding balances.

Beginning immediately, if you have an account with balances from unpaid copays, fees for missed/late canceled appointments, and coinsurance and/or deductibles for claims that HAVE FINISHED PROCESSING through your insurance, the clerical staff have been advised to not schedule any new appointments until the balance is paid in full. Please keep 3 appointments booked at all times so that you will still have at least 2 appointments on the books. We will not cancel any appointments already on the schedule. Please pay the amount requested when you check in for your appointments to avoid this issue. We diligently try to ask for the proper amount we expect to be due after your insurance processes your claim to keep you from getting behind. We adjust the balance accordingly, when needed, after we receive the final decision from your insurance. However, policies with co-pays do require the payment at the time of service. Payment can be made in person, over the phone, or via our website or QR codes on our statements.

We would encourage you to keep a credit/debit card on file with our office and sign to give us permission to charge your card for balances due (as needed) to be sure that there is no disruption to your care.

Would you like to take advantage of this option? _____yes _____no

If you have questions or concerns, please feel free to discuss this with us.

I am aware of the policy stated above.

Name

Date

January 11,2024

Prime Behavioral Health, LLC

647 Hill Rd. North, Unit B
Pickerington, OH 43147
614-833-6900

711 North Columbus St., Ste. 100
Lancaster, OH 43130
740-653-6500

We like to keep your information current. Please list anyone to whom we may speak or leave a message in regard to appointments or payments/billing along with their relationship to you.

NAME RELATIONSHIP

Signature _____ Date _____

APPOINTMENT REMINDERS BY PHONE, TEXT AND/OR EMAIL

We can now send you appointment reminders by email or SMS text. **PLEASE READ THE FOLLOWING:** The appointment reminder will include only the date and time of your appointment and your service provider’s name. We will not encrypt the messages. Health care information sent by regular e-mail or SMS text could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email or SMS text, please confirm that you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

Failure to receive appointment reminder by call, SMS text, or email does not release the responsible party of any responsibility for a charge that may be incurred for a missed appointment or late cancellation (less than 24 hours). You are responsible for keeping the card that is available for you at the window when you schedule your appointments or for appointments made by phone.

By checking a box below that enables E-mail reminders or SMS text reminders, and entering an email address or phone number, you acknowledge that you have received the information shown above and acknowledge your consent.

Enable email reminders _____
Enable SMS text reminders _____
Phone call only _____

Recipient email: _____

Recipient Mobile Number: _____

