DYNAMIC
BEHAVIORAL CONSULTING
Psychotherapy | Evaluations | Consultations

New Client Packet

Please Bring With You to Your First Appointment

Dynamic Behavioral Consulting
1975 E. Sunrise Blvd., Suite 532, Ft. Lauderdale, Florida, 33304
Phone: 954-232-7092; Toll Free FAX: 888-236-6979
eMail: dynamicbeh@gmail.com
Web: www.DynamicBeh.com

Please pardon the paperwork prior to the first meeting with your practitioner. We request that you complete, read, and sign the attached forms as appropriate and bring them to your first session. Filling them out before your meeting will insure that the time you spend with your practitioner will get to the heart of your needs more directly.

Your practitioner will be happy to discuss any questions you have about the forms at your first session.

The forms needing your attention are as follows:

- If you wish to use insurance to pay for your behavior healthcare services, then please fill out the ***Health Insurance Information & Consent*** **form**. Please fill out as much information as possible, sign it, and fax it to 954-208-3400 so that we may verify your benefits prior to your first session.

- The ***Client Information & History*** forms provides your practitioner with basic information about you and will assist your practitioner in attending to your needs.

- The ***Psychological Services Agreement & Policies*** is required by law when you begin your professional relationship with your practitioner.

- The ***Florida Notice Form: Notice of Mental Health Practitioner's Policies & Privacy Practices to Protect the Privacy of Your Health Information ("HIPAA Leaflet")*** is standard for any health care provider and is required by HIPAA law. It is yours to have as a future reference of your privacy rights. Directly following the *HIPAA Leaflet* is a ***HIPAA Acknowledgement Form*** for you to sign indicating that you received it ("HIPAA Leaflet Acknowledgement").

- The ***Payment Contract for Services*** may be filled-out at the time of your first session with your practitioner indicating the rate of each session (if you intend to pay out-of-pocket for services) or your portion of out-of-pocket payment in the even that you are using insurance.

- The ***Release of Information Authorization Form*** is only necessary should you wish for your practitioner to communicate with others about your treatment or other aspects of your protected health information. You may receive a copy of this form at your first session.

- Upon your first visit, please bring your Driver's License and Insurance Card so that we may make an copy of them for our records.

Thank you and welcome,

Dynamic Behavioral Consulting Staff

Dynamic Behavioral Consulting

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HEALTH INSURANCE INFORMATION AND CONSENT: PAGE 1 OF 1

Client's Name: _____ Client's Ph: ( ) _____ Client's DOB: _____

Client's Address:

_____

Primary Insurance Company:

_____

Insurance Company Contact Numbers:_____

Policy Number:_____ Group Number: _____

Name of Insured: _____ Insured's DOB# _____

Insured's SS# _____ Insured's Employer: _____

Client's relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

Do you have secondary insurance? If so, please fill out the following:

Secondary Insurance Company:

_____

Insurance Company Contact Numbers:_____

Policy Number:_____ Group Number: _____

Name of Insured: _____ Insured's DOB# _____

Insured's SS# _____ Insured's Employer:

Client's relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

I authorize Dynamic Behavioral Consulting to obtain insurance benefits, submit claims, and receive payments of medical / mental health benefits on my behalf. By choosing to use my insurance for psychological services, my practitioner may be required to release certain information to the insurance company at their request. Information which may be requested includes types of services, dates / times of services, diagnosis, treatment plans, descriptions of impairment, progress of therapy, and at times case notes and summaries. If it is the case that my insurance company utilizes a managed care company, my practitioner / evaluator may need to discuss my treatment with a case manager. I understand that my confidentiality may be compromised in such as case. I realize that his / her doing so is a necessity in the efforts to secure ongoing care.

_____

Client's Signature or Insured's Signature (if different from client) Date

_____

Parent / Guardian's Signature Date

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CLIENT INFORMATION FORM: PAGE 1 OF 1

Name: _____ Date of Birth _____ Today's Date _____

Address: _____ Gender ____ Race ___ Marital Status_____

_____ Eye Color ___ Hair Color ___ Height ___ Lbs. ____

Social Security #: _____

Home Phone #: _____ Safe to call? Y N Cell Phone #: _____ Safe to call? Y N

Employer: _____ Occupation: _____

Work Phone #: _____ OK to call? Y N

E-Mail: _____

Emergency Contact:

Name: _____ Relationship to you _____

Address: _____

_____

Phone #: _____ Other Phone #: _____

I authorize my treatment provider to contact the above emergency contact person in the event of an emergency.

Signature_____ Date _____

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CLIENT HISTORY FORM: PAGE 1 0F 2

Client's Name:

_____

Please state in your own words your reason for seeking Therapy:

_____

_____

Please check any areas where you are experiencing challenges:

Grief, death, illness	____	Financial stressors	____	Legal issues	____
Work, profession	____	Family stressors	____	Health, sleep, physical challenges	____
School	____	Change in residence	____	Other loss: _____	____
Relationships	____	Loss / promotion of a job	____	Other big change: _____	____
Marriage, separation, divorce	____	Pregnancy, miscarriage birth, abortion	____	Other _____	____

Have you experienced any of the following in the past year?

Fatigue	____	Mood swings	____	Isolation / loneliness	____
Intrusive thoughts	____	Decreased concentration	____	Loss of interest in daily activities	____
Panic / anxiety	____	Memory loss	____	Feelings of guilt, worthlessness	____
Depression	____	Weight gain / loss	____	Other: _____	____
Physical violence	____	Sleep disturbances	____	Other _____	____

What role (if any) does spirituality or religion play in your life? _____

How will you know when you overcome your challenges? What will be different? _____

_____

How did you find out about my services? _____

Relationships:

Relationship / Marital History (Give names, Ages & Duration):_____

_____

_____

Children (Give names & DOB): _____

_____

Family of Origin (Give names & DOB): _____

_____

_____

Dynamic Behavioral Consulting

CLIENT HISTORY FORM: PAGE 2 0F 2

Client's Name: (Please Print):

_____

Support Systems:

Coping Skills / Self Care: _____

_____

_____

Education / Degrees: _____

_____

Friendships: _____

_____

Work / Hobbies / Interests: _____

_____

Medical & Mental Health History:

Medical History: _____

_____

_____

Current MD: _____ Date of Last Visit: _____

_____

Current Psychiatrist: _____ Date of Last Visit: _____

Current Medications & Dosages: _____

_____

_____

Previous Therapist: _____ Date of Last Visit: _____

Previous Therapy for: _____

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CONSENT FOR PRACTITIONER: PAGE 1 OF 1

This form provides you with information that is in addition to that detailed in the *Florida Notice Form: Notice of Mental Health Practitioner's Policies & Privacy Practices* (*HIPAA Leaflet*).

I am choosing to enter into psychological services with _____ at Dynamic Behavioral Consulting. I am, therefore, consenting to the treatment with the above practitioner. I understand that at any time, I have the authority to exercise my right and terminate behavioral health services with this practitioner. I also, understand that the office is comprised of independent practitioners who are each solely responsible for their own practice and that the practitioners should not be considered liable for the practice of the others at the office.

Client's Name: (Please Print):
_____

Client's Signature: _____ Date: _____

Parent / Guardian's Signature: _____ Date: _____

Dynamic Behavioral Consulting

PSYCHOLOGICAL SERVICES AGREEMENT & PAYMENTS POLICIES: PAGE 1 OF 2

PAYMENTS POLICIES

Client's Name: (Please Print):

_____

It is usual and customary for the provider and the Client to agree upon Fees by the first session. Clients are expected to pay at the beginning of each session unless agreed otherwise. Initial consultations are 50-60 minutes long, subsequent Individual sessions are 45-50 minutes long; double-sessions are 1-½ hours in length. Telephone conversations, report writing, consultation with other professionals, releases, longer sessions, travel time, etc. will be charged at the same rate, unless other arrangements are made. Please notify your practitioner if any problem arises regarding your ability to make timely payments.

Payments From Clients Using Insurance: Not all issues that are the focus of psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. You must be aware that submitting a mental health invoice for reimbursement carries some risk.

Clients utilizing insurance (in-network): Co-payments and deductible amounts are due at the time of service unless special arrangements have been made. The billing department of Dynamic Behavioral Consulting will gladly file insurance claims on your behalf; however, payments cannot be guaranteed. You will need to understand that the billing department will make every effort and several attempts to obtain payments and/or clarify your insurance carrier's decision regarding your outstanding balance. In the event that the insurance company misquoted your benefits, changed your benefits, or any other reason that the insurance company denies your claim, you will be responsible for any unpaid balances not covered by your insurance company.

Clients utilizing Insurance (out-of-network): If I am an in-network provider for your insurance carrier, then you are responsible for making payment of the agreed upon fee for services at the beginning of each session. Unless agreed upon differently, I will provide you with a receipt on a monthly basis, which you can then submit to your insurance company for reimbursement.

RESPONSIBILITY FOR UNPAID BALANCES

Payments, co-payments, and deductible amounts are due at the time of service unless special arrangements have been made. I understand that the billing department of Dynamic Behavioral Consulting will gladly file insurance claims on my behalf; however, payment cannot be guaranteed. I understand that the billing department will make every effort and several attempts to obtain payments and/or clarify my insurance carrier's decisions regarding my outstanding balance. In the event that the insurance company misquoted my benefits, my benefits changed, or any other reason that the insurance company denies my claim, I will be responsible for any unpaid balances not covered by my insurance company.

Client's Signature: _____ Date: _____

Parent / Guardian's Signature: _____ Date: _____

NO-SHOW / CANCELLATION POLICY

(Please understand that last minute cancellations and no-shows prevent others from obtaining much needed services. Thank you for your understanding.)

I am also acknowledging my understanding that since my appointment time has been set aside exclusively for me, that I am responsible for notifying my practitioner 24 hours in advance to avoid a $55 No-Show / Cancellation Fee. I am aware that my insurance company will not pay for missed appointments.

Client's Signature: _____ Date: _____

Parent / Guardian's Signature: _____ Date: _____

Dynamic Behavioral Consulting

PSYCHOLOGICAL SERVICES AGREEMENT & PAYMENTS POLICIES: PAGE 2 OF 2

Patient Name: _____ D.O.B.: _____

CREDIT/DEBIT CARD ON FILE

It is the policy of Dynamic Behavioral Consulting to retain on file a credit/debit card number for all active clients. This information is kept strictly confidential and will only be used for payment of fees to Dynamic Behavioral Consulting.

For those using insurance:

Dynamic Behavioral Consulting will submit claims to your insurance company following your visit. Once the billing office receives final payment and/or disposition from your insurance carrier the office will bill your credit/debit card on file for any amounts not paid by your insurance carrier that are considered patient responsibility. Examples of these amounts may be unpaid co-pays, co-insurance and deductibles. In many cases you will have already received an EOB (Explanation of Benefits) from your insurance company showing the unpaid amounts. This will in no way compromise your ability to question your insurance carrier's determination of payment.

AUTHORIZATION:

I have read and familiarized myself with Dynamic Behavioral Consulting's Payments Policies including Responsibility for Unpaid Balances and No-Show/Cancellation. I authorize Dynamic Behavioral Consulting to charge my payment card for any and all outstanding balances on my account to include the balance of fees not paid by my insurance carrier.

<table>
<tr><td colspan="2"></td><td>(Circle One)</td><td>(Circle One)</td></tr>
<tr><td colspan="2">Name of Cardholder (print)
_____</td><td>Visa Mastercard Discover
Other_____</td><td>Debit / Credit</td></tr>
<tr><td>Card Number</td><td>__ __ __ __-__ __ __ __- __ __ __ __-__ __ __ __</td><td>Expiration Date _____
MM/YY</td><td>Zip code associated with card
_____</td></tr>
<tr><td colspan="2"> 
</td><td>The Card security code is located on the back of MasterCard, Visa and Discover credit or debit cards and is typically a separate group of 3 digits to the right of the signature strip.

CVV Code _____</td><td></td></tr>
<tr><td colspan="2">Signature of Cardholder
_____</td><td>Date _____</td><td></td></tr>
</table>

RIGHT TO COLLECT INSUFFICIENT FUNDS

If payment is by check or credit card and either the check is returned for insufficient funds or the credit card is declined, I, _____, hereby authorize Dynamic Behavioral Consulting to reveal my name and the fact that I sought professional psychological services from Dynamic Behavioral Consulting to a collection agency or a court or both as necessary for Dynamic Behavioral Consulting to collect the fee due.

Cardholder's Signature: _____ Date: _____

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PAYMENT CONTRACT FOR SERVICES: PAGE 1 OF 1

Name of Client:

_____

_____

Street Address of Client City State Zip

Name and address of person responsible for payment of services (if different from above):

_____

Federal Truth in Lending Disclosure Statement for Professional Services
Part One: Fees for Professional Services / Self Pay Arrangements

I (we) agree to pay ***Dynamic Behavioral Consulting,*** hereafter referred to as "the office," a rate of $_____ for an initial session (defined as 50 minutes consisting of a clinical intake) and a rate of $_____ per each subsequent clinical unit (defined as 45 minutes for assessment, testing, individual psychotherapy, and relationship counseling). I (we) agree to pay a fee of $55 for missed appointments or cancellations when notice to the office is made less than 24 hours of the scheduled visit of if I arrive more than 15 minutes late for my appointment, which would constitute the need for rescheduling my appoint and result in a missed appointment without 24 hours notice. If payment is not received at the time of service, a late fee of $10 will be applied to your account. Payments may be made with cash or check. All checks returned for insufficient funds will incur an extra charge of $15.00.

Part Two: Clients with Insurance (Deductible and Co-payment Agreement)

This office has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits

1) $_____ Deductible Amount (Paid by Insured Party)
2) Co-payment _____% ($_____ each clinical unit).
3) Co-payment_____% ($_____/clinical unit) up to_____ visits.
4) The policy limit is _____per year: ___ annual ___ calendar

While the office will attempt to verify the above amounts with the insurance company, it is suggested that you confirm these provisions with your insurance company. The person responsible for payment shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles. Your insurance company may not pay for services that they consider to be non-efficacious, not medically or therapeutically necessary, or ineligible (e.g., instances where you receive services not covered by your policy, the policy has expired, or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Part Three: All Clients

Payments, co-payments, and deductible amounts are due at the time of service.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Signature(s) of Person(s) Receiving Services _____ Date _____

Signature(s) of Person(s) Receiving Services _____ Date _____

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FLORIDA NOTICE FORM
Notice of Mental Health Practitioner's Policies & Privacy Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The law required that you be provided with this Notice of the legal duties and the privacy practices with respect to your PHI (Protected Health Information). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

Florida Law and Health Insurance Portability & Accountability Act of 1998 (HIPAA) require practitioner's to maintain the confidentiality of all your health care records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally. It is a federal law that gives you significant new rights to understand and control how your health information is used. If you have any questions about this Notice, please ask your behavioral healthcare practitioner.

I. USES AND DISCLOSURES FOR TREAMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Your protected health information (PHI) may be **used** or **disclosed** for **treatment, payment**, and **health care operation purposes** with your **consent**. In order to provide you with or coordinate health care treatment and services, your behavioral healthcare provider may review your health history to form a diagnosis and treatment plan, consult with other practitioners about your care, delegate tasks to ancillary staff, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other providers, etc.

In order to bill or collect payment from you, an insurance company, a managed care organization, a health benefits plan, or a third party your behavioral healthcare practitioner may need to verify your insurance coverage. Your behavioral healthcare practitioner may also need to submit your PHI on claim forms in order to get reimbursed for services, obtain pre-treatment estimates or prior authorizations from your health plan.

Your behavioral healthcare practitioner may contact you by telephone, electronic mail, or U.S. mail. Please inform your behavioral healthcare practitioner of the telephone number(s) that you want to be reached at and the procedure you want followed when or if another individual answers the call. Your behavioral healthcare practitioner will automatically leave a voicemail message with the number(s) you provide and mail information to the address you list us unless you indicate otherwise.

II. USES AND DISCLOSURES REQUIRING AUTHORIZAION

You may request **"authorization"** to use or disclose information for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the practitioner is asked for information for purposes outside of treatment, payment and health care operation, the practitioner will obtain an authorization from you before releasing your psychotherapy notes.

"Psychotherapy notes" are notes that have made about conversations during a private, group, joint, or family counseling session, consultation, or testing administration which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing.

You may not revoke an authorization to the extent that (1) Your behavioral healthcare practitioner has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer to the right to contest the claim under the policy.

III. USES AND DISCLOSURES WITH NEITHER CONSENT OR AUTHORIZATION

Exceptions to maintaining privacy occur under state law and under strictly limited circumstances. Under these circumstances, your PHI may be used or disclosed without your permission, consent, or authorization for the following purposes:

Serious Threat to Your Health or Safety or the Health or Safety of Other Persons: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, communication and relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities will be disclosed.

Child Abuse: If there is a reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that the practitioner report such knowledge or suspicion to the Florida Department of Child and Family Services.

Adult and Domestic Abuse: If there is a reasonable cause to suspect that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, the law requires the practitioner to report such suspicion to the Central Abuse Hotline.

Health Oversight: If a complaint is filed against your mental health practitioner with the Florida Department of Health on behalf of the Board of Psychology, the Board of Clinical Social Work, Marriage & Family Therapy & Mental Health Counseling, or Florida Board of Medicine and Nursing, the Department has the authority to subpoena confidential mental health information from the practitioner relevant to that complaint.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, information will not be released without the written\authorization of you or your legal representative, or a subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Worker's Compensation: If you file a worker's compensation claim for a work related injury or illness, your PHI and relevant records must be furnished upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier.

Dynamic Behavioral Consulting
HIPAA Leaflet: PAGE 3 OF 3

To Family Members, Friends and Others: If you are in an emergency situation involving you or another person (e.g. your minor child) and you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, we have been unable to locate you, we may, based on professional judgment and the surrounding circumstances, determine that disclose is in the best interests of you or the other person. In these emergency situations, your PHI will be disclosed, but only as it pertains to the care being provided and you will be notified of the specific disclosures as soon as possible after the care is completed.

IV. PATIENT'S RIGHTS

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, the provider is not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen. Upon your request, your bills will be sent to another location).

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in the mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, your practitioner will discuss with you the details of the request process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. This request may be denied. On your request, you will have a discussion with your practitioner about the details of the amendment process.

Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, you practitioner will discuss with you the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of the Notice even if you have agreed to receive the notice electronically.

V. COMPLAINTS

If you are concerned that your privacy rights have been violated, or you disagree with a decision that was made about access to your records, you may contact the Security of Department of Health & Human Services. There will not be any retaliation against you for exercising your right to file a complaint.

VI. EFFECTIVE DATE RESTRICTIONS AND CHANGES TO PRIVATE POLICY

This notice is currently in effect and has been so since May 1, 2006. Your behavioral healthcare practitioner reserves the right to change the terms of this notice at any time as authorized by law and to make the new notice provisions effective for all PHIs that your behavioral healthcare practitioner maintains. The changes will be effective immediately. If changes are made, they will be posted along with its effective date, in the business office. Also, upon request, you will be given a copy of the current Notice.

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HIPAA Leaflet Acknowledgement: PAGE 1 OF 1

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF POLICIES AND PRIVACY PRACTICES
YOU MAY REFUSE TO SIGN THIS DOCUMENT

The undersigned acknowledges receipt of a copy of the currently effective Notice of Mental Health Practitioner's Policies & Privacy Practices.

A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____

Please print your name

_____

Please sign your name Date signed

If you are the legal representative of the client, please print the client's name(s) and describe your authority.

_____

If you have any questions about this form, or the attached Notice, please contact our privacy officer, Dr. Royce Jalazo.

Office Use Only

As a privacy officer, I attempted to obtain the client's (or representative's) signature on this acknowledgment but did not because:

__It was emergency treatment

__The Client refused to sign

__The Client was unable to sign because: _____

__Other (Please describe):
_____

Signature of Privacy Officer

_____

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Fill this out ONLY if you wish for us to release your information to someone.

RELEASE OF INFORMATION AUTHORIZATION FORM: PAGE 1 OF 1

Client Name: _____ Date of Birth: ____/____/_____ Age: _____

I, _____hereby authorize _____ and
Client/Legal Guardian *Behavioral Healthcare Practitioner*
Dynamic Behavioral Consulting to:

( ) Release Protected Health Information to:
( ) Receive Protected Health Information from:
( ) Share Protected Health Information with:

_____
Name of Facility/Individual

_____
Address
(_____) _____ (_____) _____
Phone Number *Fax Number*

Purpose of this disclosure:

( ) To facilitate treatment and/or evaluation of myself or a family member
( ) Other: _____

This authorization shall expire:

( ) When the purpose for which this consent was given has been accomplished
( ) Once treatment has been terminated
( ) Date: _____

I have been informed that I may revoke this authorization at any time and for any reason by written communication to _____, my behavioral healthcare provider. In order for the revocation of this authorization to be effective, it must include: Client's name, address, phone number, and date of birth; Effective date of the revocation of the Authorization to Release Protected Health Information; Client and/or Legal Guardian's signature. All requests must be sent to _____ and are not effective until received. I understand that only information obtained or produced by _____ is subject to release. I certify that this form has been fully explained to me and that I understand its contents. A photocopy of this Release of Information will be considered as valid as the original.

I understand that information sent, released, or disclosed pursuant to this Release of Information Authorization form may be subject to additional disclosure by the recipient of your information and is no longer protected by HIPAA Privacy Laws.

_____
Client's name *Signature of Client / Parent or Guardian* *Date*

_____
Printed Name of Practitioner *Signature of Clinician/Provider* *Date*