AUTHORIZATION TO TREAT MINORS

☐ This is a referral from the Division for Children, Youth, and Families (DCYF)

☐ This is not a referral from the Division for Children, Youth, and Families (DCYF)

SOURCE OF CONSENT

☐ Parent _____ Date: _____

☐ Legal Gua _____ Date: _____
(attach a copy of guardianship documentation)

☐ Court Ord _____ Date: _____
(Court Order number - please attach a copy)

OUTPATIENT SERVICES CONTRACT & HIPAA NOTICE FORM

I have read and discussed the Warren Street Family Counseling Outpatient Services Contract with my therapist. My signature below indicates that I agree to abide by its terms in my professional relationship with WSFCA. My signature also serves as an acknowledgement that I have received the HIPAA Notice Form. I am also aware and agree that I may be billed $_____ for a missed appointment or inadequate notice.

initial _____

EMAIL AND CELL PHONE CONTACT

I understand that email and cell phone contact is not always private. If I have written or given my cell phone number or email address then my signature below gives permission for the therapist to use this method of contact.

initial _____

FINANCIAL RESPONSIBILTY STATEMENT

I understand that I am responsible for charges incurred that are not covered by my insurance. I understand that I am responsible for understanding my coverage and for knowing when the limits of my coverage are being exceeded. I understand that I am responsible for obtaining prior authorization for services from my insurance company if they require prior authorization. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits to Warren Street Family Counseling. A copy of this signature is as valid as the original.

initial _____

_____ _____
Client Signature *Parent/Guardian Signature*

_____ _____
Date *Therapist*