NORTHSIDE BEHAVIORAL HEALTH CENTER

MR# (Office Use Only):	Date:	Social Security#: _____ - _____ - _____
Last Name:	First Name:	Middle Initial:
Address 1 (Mailing):		
Address 2 (Physical):		
City:	State:	Zip: County:
Gender: ___Male ___ Female	**Date of Birth:**	**Age:**
Home Phone: ( )	Work Phone: ( )	Other Phone: ( )
Who referred you to Northside?		

Employment Status (circle one)

If Working: Full Time Active Military Part Time Unpaid (Family Business)

If Not Working: Homemaker Student Disabled/Unable to Work Criminal Inmate Inmate-Other
Not Authorized to Work Retired On Leave of Absence Unemployed (in Labor Force)

Marital Status (circle one): Single Married Divorced Separated Widow Cohabitate Child Reg Domestic Partner

Primary Language:	**Language(s) Spoken:**

Race (circle one): White Black Native American Alaska Native Asian Hawaiian/Pacific Islander
Multi Racial Other

Ethnicity (circle one): Puerto Rican Mexican Cuban Mexican -American Haitian
Other Latino Non-Hispanic Other Hispanic None of the Above

Religion:

Education Level:

No Years of Schooling	Associate Degree	Doctorate Degree
Kindergarten	Bachelor Degree	Special School
Nursery School/Preschool/Head Start	Master Degree	Vocational School
School Grade: _____	Professional Degree	College Undergraduate Year 1 2 3 4
High School Graduate (Diploma/GED		

Living Arrangements (circle one)

Assisted Living Facility (ALF)	Hospital	Mental Health Assisted Living Facility (ALF)
Dependent Living - with Non-Relative	Independent Living – Alone	Nursing Home
Dependent Living - with Relatives	Independent Living - with Non-Relatives	Other: _____
Foster Care/Home	Independent Living - with Relatives	Group Home (Residential, Rehab, etc.)
Homeless	Jail or Correctional Facility	Supported Housing

Current Living Situation (circle one): Stable Homeless Shelter Streets

Veteran Status

Military Service Yes No	**Military Related Disability** Yes No

If you answered "NO" to service question – Please STOP and go to the "DISABILITY STATUS" on next page

Military Status:	Active	Reserve	National Guard	Inactive	Veteran	Retired
Last Branch of Service:	Air Force	Army	Coast Guard	Marines	Navy	Public Health
Discharge Type:	Honorable	General	Medical	Dishonorable		
Discharge Year:						

Last Name: _____

First Name: _____

MR#: _____

NORTHSIDE BEHAVIORAL HEALTH CENTER

Insurance/Guarantor Information				
Circle One Insurance Type: No Insurance Medicaid Private Insurance Medicare Other:				
Private Insurance Name:		Policy #:		
Address:				
Phone #:				
Name of Person Financially Responsible:			Relationship:	
Address of Person Financially Responsible:				
Phone # of Person Financially Responsible:				
SSN #: - -	Gender: Male Female		DOB: / /	
Employment Status:				
Employer Name:				
Employer Address:				
Emergency Contact:				
Name:	Relationship:		Living with you? Yes No	
Address:				
City:	State:	Zip:	County:	
Home Phone: ( )	Work Phone: ( )		Other Phone: ( )	
Individual Income: $	**Circle One**: Weekly Bi Weekly Monthly Yearly			
Total Family Income: $	**Circle One**: Weekly Bi Weekly Monthly Yearly			
Additional Source of Income (circle): SSI SSDI AFDC Food Stamps Cash (SSI) Child Support Other:				
Number of Children in Household:		Number of Adults in Household:		
Disability Status - please circle Yes or No:				
Hearing Disability	Yes No			
Physical Disability	Yes No			
Visual Disability	Yes No			
Speech Disability	Yes No			
Learning Disability	Yes No			
Limited English	Yes No			
Next Of Kin				
Name:		Relationship:		
Address:				
City:	State:	Zip:	Phone: ( )	
Does the individual seeking services have a Legal Guardian: Yes No				
If YES, Legal Guardian's Name:				
My signature is to certify that the above information is true and accurate.				

Signature of Individual Completing Form **Date**

Last Name: _____

First Name: _____

MR#: _____

Northside
MENTAL HEALTH CENTER

NORTHSIDE FINANCIAL APPLICATION FOR FUNDING

CLIENT Name:_____ Date of Birth:_____

Pregnant ☐ Yes ☐ No Disabled ☐ Yes ☐ No Marital Status ☐ M ☐ S ☐ D ☐ W U.S. Citizen or legal resident ☐ Yes ☐ No

Address: _____ Mailing Address: _____ Email Address:_____
_____ _____Phone: _____

HOUSEHOLD INFORMATION Households are defined as spouses, parents of minors/legal guardian, minors and/or siblings under 21 living together

Household Members	Date of Birth	US Citizen Legal Resident Y/N	Relationship to Client	Tax Filing Status Choose Individual, Joint, Dependent, Not Filing

HOUSEHOLD INCOME List all income for household members listed above

Name of household member with income in the past 6 months	Income Source Employer Name, Self-Employment, Odd Jobs, No Income, Workman's, Unemployment Compensation, pensions, rental income, trust funds, child support, alimony, Social Security, Veteran's Administration	Monthly Gross Income List Current Income	Yearly Gross Income List total income for the past 6 months
	Total:		

Have you applied for:
Circle all that apply

Medicaid

Social Security Disability

County Medical Coverage

Workers Compensation

Health Insurance Marketplace

If you claim no income, please tell us who is supporting you: _____

Is there health insurance to cover some or all of the cost of your visit? ☐ Yes _____ ☐ No
Insurance/Policy #

Northside Behavioral Health reserves its right to change any decision made in reliance of this form, including the reversal of a write-off, if the submitted information is inaccurate/false. I certify that the information above is correct and understand that in accordance with FL Statute 817.50 providing false information to defraud a health care provider for the purpose of obtaining goods or services is a misdemeanor in the second degree. I grant **Northside Behavioral Health** authorization to verify information given through a consumer credit report if needed.

_____ _____ _____ _____
Client/Guarantor Signature Date Witness Signature (notary not required) Date

Northside Behavioral Health
Orientation to Services

Name: _____ Case # _____

Date of Admit: _____

General Orientation: ☐ **Northside Orientation Guide Provided**
☐ **Northside Orientation Guide Previously Provided**

My Rights and my responsibilities	Corporate responsibility
Ways I can provide input	Standards of professional conduct
Confidentiality and Notice of Privacy Practices	Consent to treatment
Grievance and appeal process	Infection control practices
Health and safety practices	Advanced Directives
Response to potential risk	Psychiatric Advanced Directives
Financial obligations	Voter Registration
Important phone numbers including Abuse Registry number	

I received information on the above items and understand I can ask questions at any time.

_____ _____
Client Date / Time

_____ _____
Legal Guardian Signature (if applicable) Date / Time

ASSESSMENT SELF REPORT INFORMATION

For parents please complete this form answering each question for your child.

First Name:	Last Name:

Goals:

Please let us know in detail what you need help with (issues you are experiencing):

Please check all that apply:

☐ Danger to Self	☐ Danger to Others	☐ Argumentative	☐ Violent
☐ Cutting Self	☐ Depressed	☐ Hallucinations	☐ Delusions
☐ Paranoia	☐ Agitation	☐ Anxiety	☐ Mania
☐ Mood Swings	☐ Isolation	☐ Obsessions	☐ Impulsive

☐ Other: _____

Family History of Mental Health and Substance Abuse ☐ None/Denies

Who	Mental Health / Substance Abuse	Negative Impact for You
	☐ Mental Health ☐ Substance Abuse	☐ Yes ☐ No
	☐ Mental Health ☐ Substance Abuse	☐ Yes ☐ No
	☐ Mental Health ☐ Substance Abuse	☐ Yes ☐ No
	☐ Mental Health ☐ Substance Abuse	☐ Yes ☐ No

Your History of Mental Health Services ☐ None/Denies

Service Type (Crisis Unit, Outpatient, Residential, etc.)	Diagnosis or Issue	Dates of Service	Outcome of Service
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor

Your History of Substance Use ☐ None/Denies

Type of Substance	Age When First Used	Age When Last Used	Would you like to address in treatment?
☐ Alcohol (beer, wine, and liquor)			☐ Yes ☐ No
☐ Tobacco (cigarettes)			☐ Yes ☐ No
☐ Marijuana			☐ Yes ☐ No
☐ Synthetics (spice, bath salts, etc.)			☐ Yes ☐ No
☐ Inhalants (huffing)			☐ Yes ☐ No
☐ Hallucinogens (acid, mushrooms, etc.)			☐ Yes ☐ No
☐ Stimulants (caffeine, speed, meth, etc.)			☐ Yes ☐ No
☐ Sedatives (xanax, valium, etc.)			☐ Yes ☐ No
☐ Opiates (heroine, suboxone, methadone, roxy, etc.)			☐ Yes ☐ No
☐ Crack/Cocaine			☐ Yes ☐ No
☐ Tranquilizers (special k, etc.)			☐ Yes ☐ No
☐ Other:			☐ Yes ☐ No

Your History of Substance Use Services ☐ None/Denies

Service Type (Detox, Outpatient, Residential, etc.)	How Long in Treatment	Response to Treatment
		☐ Good ☐ Fair ☐ Poor
		☐ Good ☐ Fair ☐ Poor
		☐ Good ☐ Fair ☐ Poor

PATIENT

Name: _____

ID#: _____

Please check all that apply in each category:

Treatment Needs:
- ☐ Medication teaching
- ☐ Goal Setting
- ☐ Signs and symptoms of stress and anxiety
- ☐ Signs and symptoms of depression
- ☐ Substance use (alcohol and/or drugs)
- ☐ Mental health concerns
- ☐ Lifestyle changes
- ☐ Daily living skills
- ☐ Wellness
- ☐ Care of physical illnesses /conditions
- ☐ Dynamics of chemical abuse
- ☐ Relapse prevention
- ☐ Trauma treatment
- ☐ Coping skills
- ☐ Domestic violence treatment
- ☐ Grief counseling
- ☐ Safety planning
- ☐ Relationship building
- ☐ Other:

Community Needs:
- ☐ Referral to Medical Doctor
- ☐ Housing
- ☐ Legal Assistance
- ☐ Financial assistance with medications
- ☐ Advanced Directives
- ☐ HIV/AIDS Resources
- ☐ Transportation
- ☐ Employment
- ☐ Support groups
- ☐ Public Assistance
- ☐ Veteran resources
- ☐ Other:

Strengths:
- ☐ I adhere to my medication plan
- ☐ I manage my health care needs
- ☐ I live independently
- ☐ I have a positive support system
- ☐ I am communicative
- ☐ I am financially stable
- ☐ I have a good sense of humor
- ☐ I am motivated
- ☐ I am spiritual
- ☐ I exercise regularly
- ☐ I make good grades
- ☐ I am respectful
- ☐ Other:

Abilities/Interests:
- ☐ I am creative
- ☐ I am athletic
- ☐ I have a good sense of humor
- ☐ I advocate for myself
- ☐ I have good social skills
- ☐ I volunteer in my community
- ☐ I have good parenting skills
- ☐ I am able to manage time well
- ☐ I empathize
- ☐ I have a hobby
- ☐ I manage money well
- ☐ I am organized
- ☐ I participate in sports/clubs
- ☐ I enjoy reading
- ☐ I enjoy writing/drawing
- ☐ Other:

Preferences:
- ☐ Male Counselor
- ☐ Female Counselor
- ☐ Counselor not in recovery
- ☐ Counselor in recovery
- ☐ To live independently
- ☐ AM Appts
- ☐ PM Appts
- ☐ Not address substance use
- ☐ Not address mental health
- ☐ Not address physical concerns
- ☐ Medication management
- ☐ Individual therapy, not group
- ☐ Group therapy
- ☐ Community resources
- ☐ Religious/Spiritual considerations
- ☐ Auxiliary aids for hearing/seeing
- ☐ Family involved in treatment. If so, who?

_____

- ☐ Other:

Do you have any Advanced Directives? ☐ Yes ☐ No
- ☐ Living Will
- ☐ Durable Power of Attorney
- ☐ Do Not Resuscitate
- ☐ Proxy
- ☐ Surrogate Medical
- ☐ Psychiatric

If you answered No, Do you want information about Advance Directives?
☐ Yes ☐ No

Is there anyone you would like for us to contact in the event you need a higher level of care? ☐ Yes ☐ No
If Yes, who? _____

If you need a higher level of care such as a crisis stabilization unit or hospital, do you have a preference of where you'd like to go?
☐ Yes ☐ No
If Yes, where? _____

Do you want information on Psychiatric Advanced Directives?
☐ Yes ☐ No

Patient/Guardian Signature: _____ Date: _____

ASSESSMENT SELF REPORT INFORMATION

PATIENT

Name: _____

ID#: _____

MEDICAL HISTORY SELF REPORT

First Name: _____ Last Name: _____ Age: _____

Height: _____ Weight: _____ Pregnant: ☐ Yes ☐ No If "Yes", Are you receiving prenatal care? ☐ Yes ☐ No

Primary care physician: _____ Phone #_____ Address: _____
Psychiatrist: _____ Phone #_____ Address: _____
Pharmacy Name: _____ Phone #_____ Address: _____

Currently Prescribed Medications:

Medication	Was it Helpful?	Medication	Was it Helpful?	Medication	Was it Helpful?
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No

Past Prescribed Medications (no longer prescribed):

Medication	Is it Helpful?	Medication	Is it Helpful?	Medication	Is it Helpful?
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No

Over the Counter Medications:

Medication	Is it Helpful?	Medication	Is it Helpful?	Medication	Is it Helpful?
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No

Allergies or Adverse Reactions to any **Meds**, **Food**, or **Environment**?	☐ Yes ☐ No	List:

Please check if you (S=Self) or a member of your family (F=Family Member) have had any of the following?

S	F		S	F		S	F		S	F		S	
☐	☐	Emphysema	☐	☐	Diabetes	☐	☐	Glaucoma	☐	☐	Tuberculosis	☐	Venereal Disease
☐	☐	Asthma	☐	☐	Thyroid Disease	☐	☐	Heart Disease	☐	☐	Hypertension	☐	Head Injury
☐	☐	Kidney Problems	☐	☐	Epilepsy	☐	☐	Hearing/Eye Issues	☐	☐	Arthritis	☐	Psychological Testing
☐	☐	Bladder Problems	☐	☐	Liver Disease	☐	☐	Hepatitis	☐	☐	Other: _____	☐	HIV/AIDS

Please check any symptoms you have had in the last three (3) months?

☐ Shortness of Breath	☐ Fainting	☐ Chest Pain	☐ Intestinal Problems	☐ Bronchitis
☐ Dizziness	☐ Coughing	☐ Bladder Problems	☐ Allergies	☐ Headaches
☐ Seizures	☐ Swelling	☐ Weakness	☐ Light Headedness	☐ Problems with Motor Skills
☐ Loss of Consciousness	☐ Other: _____			

Please check any conditions you have had in the <u>past</u> or <u>recently</u>:

Past	Recently		Past	Recently		Past	Recently	
☐	☐	Insomnia	☐	☐	Low energy	☐	☐	Thoughts of suicide
☐	☐	Crying spells	☐	☐	Irritability	☐	☐	Nightmares
☐	☐	Repetitive irrational behavior	☐	☐	Obsessions	☐	☐	Memory problems
☐	☐	Trouble concentrating	☐	☐	Indecisiveness	☐	☐	Irrational Fears
☐	☐	Extreme nervousness	☐	☐	Sexual problems	**Nutritional/Eating:**		
☐	☐	Frequent & serious loss of temper				☐	☐	Appetite changes
☐	☐	Seeing or hearing things that are not real				☐	☐	Weight loss or gain

PATIENT

Name:

Number:

Date of last appointment with Primary Care Physician: _____ Physician aware of above items checked for yourself? ☐ Yes ☐ No

Are you currently or do you frequently experience any physical pain that would prevent you from participating in treatment? ☐ Yes ☐ No If yes, please explain _____

Have you had any operations, medical hospitalizations, or injuries requiring medical care that may impact your treatment here? ☐ Yes ☐ No If yes, please explain: _____

Are you currently receiving treatment for any medical problems that may impact your treatment here? ☐ Yes ☐ No If yes, please explain:

_____

List any other doctors you are currently seeing and why:

_____

Date of last Dental Exam: _____ Date of last tuberculosis (TB) skin test if known: _____ Results: ☐ Positive ☐ Negative

THIS SECTION APPLIES TO CHILDREN AND ADOLESCENTS ONLY

Immunizations current: ☐ Yes ☐ No If "No", please explain: _____

Are hearing, speech, or vision contributing factors to your child's issue? ☐ Yes ☐ No If "Yes", explain: _____

Age at walking? _____ Age at talking single words? _____ Age at talking sentences? _____

Check if there was prenatal exposure to any listed: ☐ Alcohol ☐ Tobacco ☐ Other Drugs ☐ None

Check all those that apply during infancy or early childhood.

☐ Colicky ☐ Active ☐ Uncoordinated ☐ Did not enjoy being held ☐ Sleeping Problems ☐ Restless
☐ Feeding problems ☐ Head Banging ☐ Accident Prone ☐ Other _____

Developmental:

Please indicate if your child had difficulties in any of the following areas during their development:	**Unsure**	**Yes**	**No**	**If yes, explain**
Sitting up, walking, crawling etc.	☐	☐	☐	
Speech	☐	☐	☐	
Toilet training	☐	☐	☐	
Making and Keeping Friends	☐	☐	☐	
Chores/Work	☐	☐	☐	

Please circle how well your child does each of the following:

Bathing/grooming:	Never	Often Forgets	Good	Very Good
Taking medicine:	Never	Often Forgets	Good	Very Good
Cleans own room:	Never	Often Forgets	Good	Very Good
Brushing teeth:	Never	Often Forgets	Good	Very Good
Other chores:	Never	Often Forgets	Good	Very Good

_____ _____

Patient/Guardian Signature Date

PATIENT

Name:

Number:

NORTHSIDE BEHAVIORAL HEALTH SERVICES

Client Agreement and Consent

Last Name:	First Name:	MI
MR#	RU#:	Date:

As a condition of my admission to Northside Behavioral Health, I hereby agree to the following:

CONSENT TO TREATMENT: I hereby authorize the physician/clinician in charge of my care and Northside Behavioral Health to oversee my treatment plan and monitor my behavioral health medication as required by my behavioral health symptoms. I understand that, under the direct supervision of my treating physician, an Advanced Registered Nurse Practitioner may be utilized in my care and treatment.
I voluntarily consent to treatment.

AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH INFORMATION: I hereby authorize Northside Behavioral Health and or/any treating physician/clinician to obtain, use and/or release information (current and historical) for the purpose of treatment, payment and/or operations as outlined in the Notice of Privacy Practices. This may include collection agencies and credit bureaus and will be limited to the minimum amount necessary (including psychiatric, drug abuse, alcohol or HIV status). I hereby authorize Northside Behavioral Health and/or the treating physician/clinician to release information from my medical records to other healthcare facilities/providers to which I may be transferred for emergency services.

MEDICARE / MEDIGAP / MEDICAID / CLIENT CERTIFICATION / RELEASEOF INFORMATION & PAYMENT REQUEST:
I certify that the information given to apply for payment under title XVIII and/or XVIII and/or Title XIX, of the Social Security Act is correct. I authorize and holder of behavioral health information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare, Medigap or Medicaid for payment to me. I understand that I am responsible for any health insurance deductibles and co-payments. An itemized statement is available upon request.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, grant and transfer to Northside Behavioral Health, now and in the further, all my right and interest in the following: (a) Any and all benefits now or in the future owed or receivable by me or on my behalf from any insurer, health maintenance organization, PPO, employer health benefit plan or other third-party payor for those costs I incur in receiving services from Northside Behavioral Health. and (b) Any and all monies or other benefits paid or payable to me and/or my attorneys from any settlement, judgment or verdict which is obtained as a result of the injury or medical condition for which my debt to Northside Behavioral Health was or is to be incurred. I agree that should the amount received by Northside Behavioral Health be insufficient to cover the entire expense of service, including the co-payment and the deductible, I will be personally responsible for payment of the difference. I also understand and agree that if the nature of the services rendered by Northside Behavioral Health is not covered by said insurance policy, I am responsible to Northside Behavioral Health for payment of the entire bill.

GUARANTEE OF PAYMENT: For value received, the undersigned does agree to guarantee and promise to pay Northside Behavioral Health and/or any treating physician all charges and expenses incurred in the treatment, including those expenses not covered by any insurance policy presently in force, including any co-payment and/or deductible. If any action at law or inequity is brought to enforce this agreement, Northside Behavioral Health understanding that all bills are payable and become due upon presentation. I understand and agree that if Northside Behavioral Health is required to bring claim or file an action to enforce this agreement, Northside Behavioral Health shall be entitled to recover from me its reasonable attorney's fees, court costs, and any other costs of collections, in addition to the amount owed Northside Behavioral Health for its services.

DENIAL OF PAYMENT AUTHORIZATION: Northside Behavioral Health will make every effort to obtain payment authorization/preauthorization for all managed care contractual agreements. If, however, a denial is received, the Client/guarantor will be responsible for all incurred charges and penalties, payable and become due upon presentation.

CLIENT

NORTHSIDE BEHAVIORAL HEALTH SERVICES

Client Agreement and Consent

RELEASE OF RESPONSIBILTY AND LIABILITY FOR PERSONAL VALUABLES: I understand and agree that Northside Behavioral Health is not responsible for personal valuables or belongings brought into, or claimed to have been brought into the facility, by named Client/client or his/her agent. Personal valuables or belongings include, but are not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devises (such as hearing aides, artificial limbs, or assist devices such as: canes, walkers, or wheelchairs), credit cards, jewelry and money. I understand that a locked safe is available for securing my personal valuables small enough to fit in a security envelope.

DISCLOSURE OF ADMISSION FOR TREATMENT
Northside Behavioral Health will neither confirm nor deny your admission status without your consent /authorization, except when required by the Florida's Mental Health Act (Baker Act), S.394.4597 AND S. 394.4599, F.S.

AUTOMATED COMMUNICATION: I hereby expressly consent to allow the Facility and/or Provider (and/or business associates/third party collection agencies of the Facility and/or Provider) to contact me (including, but not limited to, through the use of contact information and/or telephone numbers that I have provided to the Facility and/or Provider) via telephone, text message, cellular phone, electronic mail and/or any other form electronic communication using pre-recorded messages, auto-dialers, and/or other forms of automated/electronic communication. Electronic communication can be intercepted in transmission or misdirected. Your use of electronic communication to us indicates that you acknowledge and accept the possible risks associated with such communication.

RECEIPT OF CLIENTS RIGHTS & RESPONSIBILITIES, NOTICE OF PRIVACY PRACTICES, AND ORIENTATION GUIDE: By my signature on this document, I acknowledge receipt of a Client's rights and responsibilities pursuant to Florida statute 381.026, a Notice of Privacy, and a copy of the Orientation Guide, prior to or at the time of admission.

I HEREBY AGREE THAT THE TERMS OF THIS AGREEMENT HAVE BEEN COMPLETELY READ, FULLY UNDERSTOOD AND ARE VOLUNTARILY ACCEPTED; THAT I HAVE VOLUNTARILY AND WITH FULL UNDERSTANDING EXECUTED THIS AGREEMENT; THAT I HAVE ACCEPTED ITS TERMS AND CONDITIONS; THAT I WILL RECEIVE A COPY OF THIS AGREEMENT UPON REQUEST; AND THAT I AGREE THAT A COPY OF THIS AGREEMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.

Client Signature	Parent/Guardian Signature	Date	Time
Signature of Client's Authorized Representative		Date	Time
Witness Signature		Date	Time

CLIENT