KindMind Counseling

CLIENT DEMOGRAPHICS & INSURANCE

General Information

First Name: _____ Last Name: _____

DOB: _____ Legal Sex: _____ Preferred Pronouns: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mobile: _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Cohabitating

Name of spouse or significant other: _____

If client is a minor, are there any custody arrangements we should be aware of?

_____

Emergency Contact

First Name: _____ Last Name: _____

Phone: _____ Relationship: _____

Do you authorize this person to discuss care or treatment with the office in the case of an emergency? ☐ Yes ☐ No

Health Insurance

Primary Insurance: _____ Policy Holder's Name: _____

Policy Number: _____ Group Number: _____

Policy Holder's DOB (mm/dd/yyyy): _____ Relationship to You: _____

Policy Holder's Street Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Insurance (if any): _____ Policy Holder's Name: _____

Policy Number: _____ Group Number: _____

Policy Holder's DOB (mm/dd/yyyy): _____ Relationship to You: _____

KindMind Counseling

Reason for seeking counseling:

_____

_____

_____

_____

_____

_____

_____

ASQ: Suicide Risk Screening Tool

1. In the past few weeks, have you wished you were dead? ☐ Yes ☐ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No
3. In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No
4. Have you ever tried to kill yourself? ☐ Yes ☐ No

   If yes, how? _____

   When? _____
5. Are you have thoughts of killing yourself right now? ☐ Yes ☐ No

   If yes, please describe: _____

Consent to Treatment & Patient Bill of Rights

In working with a mental health professional, you are taking a very important step in your mental wellness plan. You and your provider will be entering into a protected relationship. Treatment may involve a multidimensional family approach and, due to this, consent for treatment is needed from all those who will be attending sessions. During treatment, we will do our very best to accurately provide a diagnosis and design a treatment plan to best serve your needs. Recommendations may include, but are not limited to, specific types of therapy, interventions, pharmacotherapy, consultation, and/or referral for alternative treatment. If necessary, we may request to coordinate care with your primary care physician or other designated caregivers to ensure you are receiving the best possible care.

As our client, you have a right to confidentiality. However, confidentiality does not apply under certain situations. As mandated reporters we are obligated, by law, to report any suspicion of child abuse or neglect. In addition, we have a duty to protect if we suspect an individual is in danger of harming themselves or others or if an individual makes threats of harm to themselves or others. Except in these situations, minors receiving services have the right to confidentiality, even from their parent(s) and/or legal guardian(s). We ask that you please respect this right to confidentiality as establishing trust between the client and provider is a key component of the process. If there is any concern of harm, including the presence of suicidal or homicidal thoughts, plans or intent, or report of any other dangerous or life-threatening behaviors, we will inform you. If you require us to communicate/share information with an individual or entity (physician, probation officer, lawyer, Social Security, etc.), you will need to complete a Release of Information (ROI) form giving us permission to share information with said individual. This release of information will be valid for a period of one year. You have the right to revoke this privilege at any time by completing a Revocation of Authorization to ROI form.

I do hereby seek and consent to take part in treatment provided by KindMind Counseling ("KindMind"). I understand that developing a treatment plan with my provider, regularly reviewing our work toward achieving my therapy goals and objectives, and regular attendance are all in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to what types of results I may see as a result of services received at KindMind. I understand that KindMind reserves the right to work with a collection agency if, for any reason, my account is not paid in full after three months of the date of billing. I understand my contact information and statement may be released to the collection agency. I am aware that I have the right to stop treatment with KindMind at any time. I understand that I may lose other services (such as pharmacotherapy), experience a worsening of symptoms, or other problems as a result of my decision to stop treatment. For example, if my treatment has been court-ordered, I will have to answer to the court system. I am aware that KindMind, its providers, and any other employees and representatives DO NOT participate in custody proceedings. I am aware that if I attempt to contact my provider or agree to allow my provider to contact me via telephone, email, text message or any other form of communication over the internet or electronically, my information may not be completely secure. In the event that my information is intercepted, KindMind is not responsible for the breach of client privacy.

Individuals receiving mental health services have the right to receive services that take into account the best available research evidence on what has been shown to work; to consider how that evidence may or may not fit with your personal goals and values; to decide whether any given mental or behavioral health service aligns with your own developmental, cultural, and community needs and strengths; to understand how your progress will be measured and how you and your provider will know that services are working; to ask for changes to the services to increase the chance that they will work for you; and to ask your provider about what services they're trained to give and options that other providers may be able to offer to help you get better

Telehealth (Telemedicine) Consent

Telehealth refers to providing clinical therapy and/or medication management services remotely using telecommunications technologies such as video conferencing or telephone. Telehealth sessions shall not be recorded in any way unless agreed to in writing by mutual consent of all parties involved. Although there are benefits of telehealth, there are some differences and risks associated with conducting telehealth sessions. I understand that my provider has the right to decide whether telehealth is an appropriate form of treatment for me.

KindMind and its providers will take all necessary and reasonable steps to ensure your privacy. It is important for you, however, to ensure you are conducting your session from a room where others are not present and cannot overhear the conversation. I

understand that my provider retains the right to promptly reschedule and end a session if they suspect privacy has been compromised. I understand that if I am not comfortable with the location from which my provider is conducting my session, I have the right to promptly end the visit and call the office to reschedule with no financial penalty. Under no circumstances will a session be conducted while I am the driver or passenger in a vehicle.

There are many ways that technology issues might impact telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies. I acknowledge and accept this risk.

I understand the same fee rates will apply for telehealth as they apply for in-person appointments. I understand it is important for me to contact my insurer to determine if there are additional fees associated with conducting sessions via telehealth. I understand some payers may not cover telehealth sessions and, as such, I am responsible for these costs out-of-pocket.

I understand and agree with the telehealth terms listed above and am comfortable regarding the use of telehealth to conduct appointments with my provider.

By signing below, I confirm that I have read, understood, and agree with the terms listed above and consent to treatment at KindMind.

Patient or Parent/Guardian Name (please print): _____

Patient or Parent/Guardian Signature: _____ Date: _____

HIPAA Notice of Confidentiality

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT THE PATIENT MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THAT INFORMATION.

BACKGROUND: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted by congress to help protect health coverage for workers and their families. It also addresses electronic transaction standards and the need to ensure the security and privacy of health data. KindMind Counseling (KM) is required by law to maintain the privacy of protected health information and must inform you of our privacy practices and legal duties. The security and privacy of your protected health information is the subject of this Privacy Notice.

I. Use and Disclosure of Your Protected Health Information for Treatment, Payment, and Health Care Operations

KM may use or disclose information in your records for treatment, payment, and health care operations purposes with your consent. Personal health information (PHI) refers to information in a patient's health record that could identify that patient. Use of this information refers only to activities within KM such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. Disclosure of information refers to activities outside of KM such as releasing, transferring, or providing access to information about you to other parties. Throughout this notice, the term "you" may refer to the individual who is the patient or the individual's parent, legal guardian or adult who has been legally determined to be responsible for the patient.

In providing for your treatment, KM may use or disclose information in your record to help you obtain health care services from another provider, or to assist me in providing for your care. For example, KM might consult with another health care provider, such as your child's pediatrician or another provider in-house.

In order to obtain payment for services, KM may use or disclose information from your record, with your consent. For example, KM may submit the appropriate diagnosis to your health insurer to help you obtain reimbursement for your care.

KM may use or disclose information from your record to allow health care operations (e.g., quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination).

II. Use and Disclosure Requiring Authorization

Except as described in this Notice, KM may not make any use or disclosure of information from your record for purposes outside of treatment, payment, and health care operations unless you give your written authorization. In particular, KM will need to secure an authorization before releasing psychotherapy notes which I have kept separate from the rest of your treatment records. These are notes I have made about our conversations during treatment and evaluation appointments.

You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by KM before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

III. Use and Disclosure Without Consent or Authorization

- **Child Abuse:** If KM knows of or has reasonable cause to suspect a child is or has been abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that KM report such knowledge or suspicion to the Michigan Family Independence Agency or appropriate governmental agency. If KM knows or has reasonable cause to suspect a child has been abused by a non-caretaker the

law requires KM report to the Michigan Family Independence Agency which, in turn, may be required to submit the report to other governmental agencies.

- **Adult and Domestic Abuse:** If KM knows of or has reasonable cause to suspect a vulnerable adult (disabled or elderly) has been or is being abused, neglected or exploited, I am required by law to report such knowledge or suspicion to the Central Abuse Hotline or other appropriate governmental agency.
- **Health Oversight:** If a complaint is filed against KM with the Michigan Department of Health, the Department has the authority to subpoena confidential mental health information relevant to that complaint.
- **Judicial or Administrative Proceedings:** Personal Health Information is privileged by state law. If you are involved in a court proceeding and a request is made for your records, KM will not release information without the written authorization of your or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena, or a court order. The privilege does not apply if you are being evaluated for a third party, or if the evaluation is court ordered, or in certain other limited instances. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If a patient presents a clear and immediate probability of physical harm to him or herself, to other individuals or to society, KM may communicate relevant information concerning this to the potential victim, appropriate family member or appropriate authorities.
- **Workers' Compensation:** If you file a workers' compensation claim, KM may disclose information from your record as authorized by workers' compensation laws.

IV. Patient's Rights and Provider's Duties

Patient's Rights

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected heath information. However, KM 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 to have confidential communications of PHI delivered by alternative means and/or at alternative locations. (For example, you may not want a family member to know that you are receiving counseling services. Upon your request, KM may be able to arrange to send your bills to another address.)
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in KM's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record, given your written request. This may be subject to certain limitations and fees. Upon request, KM will discuss with you the details of the request process. Please understand that older records may be destroyed, and therefore no longer available, in accordance with applicable law or standards.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your request must be in writing, and KM may deny your request.
- **Right to an Accounting:** You have the right to request an accounting of certain disclosures made by KM. Upon request, KM will discuss with you the details of the accounting process.

Provider's Duties

- KM is required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- KM reserves the right to change the privacy policies and practices described in this notice. Unless KM notifies you of such changes, however, KM is required to abide by the terms currently in effect.
- If KM makes significant revisions to its policies and procedures which might affect the privacy of your personal health information, KM will provide you with a copy of those revisions. If you are still in treatment with KM, you will be provided with a copy of the revisions in the manner permitted by law, generally by hand delivery at your next appointment. As needed, former patients may be mailed a copy of significant revisions to the most recent mailing address on file at KM. Updated notices of KM's privacy policies will always be available for review upon request at the office.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision KM makes about access to your records, or have other concerns about your privacy rights, you may contact KM's office in writing (5980 S. Main Street, Suite 101, Clarkston, Michigan 48346) or by phone (248-625-2970). KM recommends such inquiries be done in writing.

If you believe your privacy rights have been violated and wish to file a complaint with KM you may send your written complaint to KM's office address above. You may also send a written complaint to the Michigan Department of Licensing and Regulatory Affairs Bureau of Professional Licensing, Investigations & Inspections Division You have specific rights under the Privacy Rule. KM will not retaliate against you for exercising your right to file a complaint, in accordance with the provisions of applicable law. You may file a complaint online at michigan.gov/lara/file-complaint, contact LARA via telephone at 517-241-0205 or via postal mail at: Michigan Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, Investigations & Inspections Division, P.O. Box 30670, Lansing, MI 48909

VI. Effective Date, Restrictions, and Changes to Privacy Policy

Restriction: In the case of a minor child, the child's legal guardian has the right to inspect or obtain a copy (or both) of PHI in KM's mental health and billing records used to make decisions about the child for as long as the PHI is maintained in the record. However, psychotherapy notes including statements made by a child during therapy sessions will not be released, in order to protect the child's right to confidentiality, unless required by law or deemed by KM to be in the best interests of the child.

Restriction: In most cases, KM is also prohibited by law from disclosing raw psychological test data and test materials to anyone other than a licensed psychologist qualified to interpret such data.

By signing below, I acknowledge that I have received a HIPAA Notice of Confidentiality.

_____ _____

Patient/Guardian Signature Date

KindMind Counseling

PSYCHOTHERAPY POLICIES

Appointment Duration and Frequency

To ensure adequate therapeutic care, frequent therapy appointments are required. Unless arranged otherwise, clients are required to participate in a minimum of one session per month. Clients who have not completed a therapy session in greater than 30 days will be considered inactive, and the client/therapist relationship will be terminated. The client has the right to re-initiate therapy at any time; however, if a period of one year or more has elapsed, the client must complete a new intake assessment.

Illness & Intoxication Policies

If the client is ill and still wishes to be seen at their scheduled day/time, the appointment must be converted to telehealth. If the client is ill, is unable to attend via telehealth, and wishes to cancel their appointment altogether, they are still expected to provide our office with at least 24 hours' notice. As noted above, failure to do so will still result in a Late-Cancellation fee unless extenuating circumstances exist. Attending an appointment in-person while ill will result in automatically ending the appointment. The appointment will be treated as a Late-Cancel and the client will be accountable for the associated fee. The client will then be asked to leave and reschedule the appointment. The same policies apply if the client attends their appointment under the influence of drugs or alcohol. The authorities or an emergency contact may be contacted if a client enters the office under the influence of drugs or alcohol and/or attempts to leave driving a vehicle.

Minor Policies

Providers that work with adolescents/children have the difficult task of protecting the adolescent's/child's right to privacy while also respecting the parent's or guardian's right to information. Therapy is most effective when a trusting relationship exists between the counselor and the adolescent/child. Privacy is especially important in securing and maintaining that trust. In our practice, we provide individual counseling to adolescents/children and ensure the caregiver/parent is involved in the process through scheduled consultation with them (preferably with the child present). At times, the parent/caregiver may even participate in the sessions. However, to ensure a child's privacy, sessions will be primarily conducted between the adolescent/child and their therapist only. We will not provide detailed information to the parent/caregiver regarding what the child shared unless the child provides consent. Instead, general themes, ideas and recommendations will be provided as well as support and encouragement to the parent/caregiver. As mandated reporters we are obligated, by law, to inform you if your child expresses thoughts of wanting to harm themselves or someone else and/or if they report they are being harmed or have knowledge that someone else is being harmed. If it is necessary to refer your child to another mental health professional with more specialized skills, we will share that information with you. Other areas of confidentiality will be discussed during the first session with the child/adolescent in the presence of their parent/caregiver to ensure complete understanding and agreement prior to the initiation of counseling.

We do not conduct custody evaluations or determine whether one parent is "fit" or not, nor will we recommend one parent over another or focus on reunification of a child and parent. We do not testify in court about custody issues unless we are court ordered to do so. For children of divorced parents, we expect the parents to communicate with each other about services, decide who will schedule appointments, who will bring the child to treatment, etc. The provider and the child cannot be messengers between parents. It is important to note that both parents have access to their child's record, regardless of custody, unless parental rights have been revoked. Since children benefit from an expectation of some privacy, we try not to share details of what a child says or does in treatment. We will share treatment progress and notify parents of any risks of harm.

Children under the age of sixteen (16) must have a parent or guardian in the office or on premises at all times.

By signing below, I confirm that I have read, understood, and agree with the psychotherapy policies and terms listed above.

Client or Parent/Guardian Name (please print): _____

Client or Parent/Guardian Signature: _____ Date: _____

PAYMENT POLICIES & CONSENT

KindMind Counseling ("KindMind") participates with many direct pay health insurance companies and the stated fees shall be in accordance with the contractual agreements. KindMind Counseling also offers out-of-pocket (self-pay) rates if the client's health insurance is inapplicable.

I, the undersigned, agree that, regardless of insurance status, am responsible for the balance on my account for all professional services rendered. I understand that the insurance policy is between myself and my insurer and KindMind is not responsible for payments made by the insurance company. I am aware that I am responsible for all fees if the insurance company does not pay or pays an amount different than stated in this agreement. I am responsible for notifying KindMind Counseling of any changes regarding my insurance and failure to do so may result in my responsibility for the total cost of services. If the client fails to notify our office of changes to their insurance policy in a timely manner and KindMind does not have an active insurance policy on file providing coverage for services rendered with our facility, all appointments completed during this time will be billed directly to the client and will be the client's full responsibility. If my mental healthcare benefits have exhausted or coverage is no longer active, I understand that I am responsible for paying the applicable out-of-pocket (self-pay) rates if I wish to continue services. I, the undersigned, understand that if a balance has not been paid for more than ninety days and arrangements for payment have not been agreed upon, KindMind Counseling has the option of suspending or discontinuing treatment with the undersigned and using legal means to secure payment. This may involve working with a collection agency or a small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information KindMind will release regarding a client's treatment is the client's name, the nature of services provided, and the amount due, including any costs incurred in the process and all attorney and court costs associated with collecting an unpaid debt.

I understand that a minimum of a 24-hour notice is required when canceling an appointment. I understand that failure to show for an appointment ("no-show") and failure to provide proper notice of cancellation for an appointment ("late-cancel") will result in a fee of $70.00. I also understand that arrival of 15 minutes or later after the scheduled appointment time and appointments concluded less than 30 minutes after the client's arrival are considered a "late-cancel" and will be assessed as such. These fees are not covered by insurance and must be paid prior to your next scheduled appointment. These fees are applicable to all clients except those insured under a Medicaid plan. KindMind Counseling reserves the right to terminate clients at any time and under any circumstance, but treatment will be subject to automatic termination if any one of the following events occurs:

- Failure to show for two (2) consecutive appointments
- Failure to show or cancel without proper notice twice in a 30-day period
- Failure to show or cancel without proper notice four (4) times in a six-month period if insured under a commercial plan and twice in a three-month period if insured under a Medicaid plan
- Being under the influence of any illegal substance while on the premises
- Harassment and/or threatening the safety or rights of the staff members or other clients
- Non-compliance with treatment or an inability of the practice to provide the treatment required

KindMind Counseling is open from 9AM-9PM Monday – Friday, and by appointment on Saturday. However, please note that our front office and main office phone line close at 5PM during the week and are closed on weekends. Any phone calls made to our main office after hours will only be returned if a voicemail is left.

Other fees for services at KindMind that cannot be billed to a health insurance plan and are the client's responsibility are as follows:

- Out-of-pocket (self-pay) fee: $150 per intake session; $120 for each session thereafter.

- Any presence in court (including taped disposition) is subject to a fee of $500 per day. This includes where a court-ordered subpoena legally requires the provider to appear in court and/or provide a deposition. In such instances, fees will be charged and must be paid in full prior to the date of service.
- Medical Records Fees: $25 initial fee (applicable to all clients except those insured under a Medicaid plan); plus $1.00 per page for pages 1-20; $0.50 per pages for pages 21-50; $0.25 per page for pages 51+.

Payment plans with KindMind Counseling may be accommodated for patient payments. Payment plans cannot be accommodated for Late-Cancellation, No-Show, nor Late-Arrival fees. Such fees will be owed in full at the time of the scheduled service. Further, services will be paused and only one (1) future appointment will be scheduled for clients who carry a balance larger than $200 unless a payment plan is in place. Paused services may result in forfeiture of future appointments time slots (i.e. future time slots will not be reserved while services are paused). If the method of payment applied to a payment plan is invalid or declines and a valid payment method is not provided within 72 hours of the payment charge date, services may be paused until a valid payment method is provided and applied.

Any outstanding balances will be automatically charged to the card on file on the Friday following the issuance of each patient statement. If you have questions regarding your balance or payment method, please contact our office prior to the scheduled charge date.

KindMind Counseling reserves the right to update or modify its payment policies at any time. Any changes will be communicated in writing and will take effect immediately unless otherwise specified.

I authorize KindMind Counseling to bill me and charge my credit/debit/health account card on file for any of these fees if incurred and for all professional services rendered relating to my healthcare at this facility, such as co-pays, deductibles, or any other patient payments. I recognize that KindMind Counseling will charge my card as a late-cancel, late-arrival, or no-show if applicable based on the terms stated above. I verify that my credit card information, provided below, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any additional costs incurred if denied. I also understand by completing and signing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within ninety days. Lastly, I understand that KindMind Counseling reserves the right to update or modify the aforementioned policies at any time and agree to comply with any future changes made to such policies.

AS SUCH, IT IS REQUIRED THAT YOU PROVIDE VALID CREDIT/DEBIT CARD INFORMATION BELOW:

Client Name: _____

Name on Card: _____

Card Number: _____

Exp. Date: _____ CVV: _____ Zip Code: _____

By signing below, I affirm that I have read, understood, agree with, and consent to the terms listed above.

Client/Guardian Signature: _____ Date: _____

Cardholder Signature (if different than client): _____ Date: _____

KindMind Counseling

CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION FOR CARE COORDINATION PURPOSES [Optional]

Name: _____ Date of Birth: _____

Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or agency can use and share most of your health information in order to provide you with treatment, receive payment for your care, and manage and coordinate your care. However, your consent is needed to share certain types of health information. This form allows you to provide consent to share the following information regarding behavioral and mental health services as well as referrals and treatment for an alcohol or substance abuse disorder.

This information will be shared to help diagnose, treat, manage and get payment for your health needs. You can consent to share all of this information or just some information. (See FAQ at www.michigan.gov/bhconsent)

I. I consent to share my information with:

1. _____
2. _____

II. I consent to share:

☐ All of my behavioral health and substance use disorder information

☐ All of my behavioral health and substance use disorder information except: (List types of health information you do not want to share below)

_____

☐ Other: (be specific)

_____

I understand that HIPAA allows providers and other agencies to use and share much of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.

III. By signing this form, I understand:

- My information will be shared to help diagnose, treat, manage and pay for my health needs.
- My consent is voluntary and will not affect my ability to obtain mental health or medical treatment, payment for medical treatment, health insurance or benefits.
- The sharing of my health information will follow state and federal laws and regulations.
- This form does not give my consent to share psychotherapy notes as defined by federal law.
- I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back.
- I should tell all agencies and people listed on this form when I withdraw my consent.
- I can have a copy of this form.

IV. ☐ I DO NOT CONSENT TO SHARE MY PERSONAL HEALTH INFORMATION WITH ANYONE.

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

_____ _____

Signature of person giving consent or legal representative Date

Relationship to individual:

☐ Self ☐ Parent ☐ Legal Guardian ☐ Authorized Representative