****

969 Reading Rd. Suite E, Mason, Ohio 45040

(513) 294-8114

**Client Information and Acknowledgment of Informed Consent to Treatment**

I am an Ohio licensed Professional Counselor, practicing under Labors of Love Counseling and Consulting, LLC and am engaged in private practice providing mental health services to the public. For the diagnosis and treatment of mental and emotional disorders I work under the supervision of Dr. Rick Butts, LPCC-S.

***Mental Health Services***

The purpose of mental health services is to help you better understand your situation, change your behavior, or move toward resolving your difficulties. Using my knowledge of human development and behavior, I will make observations about situations and help you to develop new ways to approach them. It will be important for you to examine your own feelings, thoughts and behavior, and to try new approaches in order for change to occur.

The services offered can have risks as well as benefits. Treatment often involves discussing unpleasant issues, and you might experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health care may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

***Appointments***

Appointments are made by calling (513) 294-8114 or visiting www.thelaborsoflove.com. **Please call to cancel or reschedule at least 24 hours in advance, or you will be charged $50.00 for the missed appointment unless I determine an emergency was involved.** **You may cancel or change an appointment after you set up an account on my website,** [**www.thelaborsoflove.com**](http://www.thelaborsoflove.com)**.** Appointments are typically 60 minutes in length, but session length may vary for clinical reasons. The number of appointments depends on many factors and we will discuss this as part of your treatment planning. Since there is no way a therapist can see another client when they have a late arrival, no reductions are provided when a client arrives late for an appointment.

***Relationship***

My relationship with clients is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Please do not attempt to “friend” me on my personal Facebook or on any other social media site. You always have the right to terminate services with me at any time and for any reason.

***Goals, Purposes and Techniques***

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment I recommend and to have input into setting the goals of your therapy. As therapy progresses these goals may change. You and I will jointly determine how to effect the changes you are seeking to make for yourself. You always have the opportunity to seek either another opinion or a different therapist. I will let you know if I feel that we are not a good fit or if you might obtain better help elsewhere. I will always retain the right to terminate my therapy with you in the event that I feel you would be better served elsewhere, if I feel you are not complying with treatment requests, or if payments due to me remain unpaid. In the event that I terminate services with you I will offer you referrals.

***Confidentiality***

Laws protect the privacy of all communications between a client and a therapist. In most situations I can only release information about your treatment to others if you sign a written authorization. There are some situations where I am permitted or required to disclose information either with or without your consent or authorization. For example:

* If you are involved in a court proceeding and a request is made for information concerning your treatment, I cannot provide such information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order me as your therapist to disclose information;
* If a government agency is requesting the information, I may be required to provide it;
* If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend myself;
* If you file a worker’s compensation claim, I may be required, upon appropriate request, to provide a copy of your records, or a report of your treatment.

There are some situations in which I am legally obligated to take actions that I believe are necessary to attempt to protect others from harm, and in such cases I might have to reveal some information about your treatment. If such a situation arises, I will make every effort to fully discuss it with you before taking any action, if I deem that to be appropriate under the circumstances, and will limit disclosure to what is necessary. For instance:

* If I have reason to believe that a child, a developmentally or physically disabled or elderly adult is being neglected or abused, the law may require me to report that information to the appropriate state or local agency;
* If I believe you present a clear and substantial danger of harm to yourself and/or others, I may be obligated to take certain protective actions. This may include contacting family members, seeking hospitalization for you, notifying any potential victim(s), and/or notifying the police.

You agree that from time to time I may have the need to consult with my practice attorney regarding legal issues involving your care (this is an infrequent occurrence, but does happen from time to time). My practice attorney is bound by confidentiality rules also. In addition, I will reveal only the information that I need to reveal to receive appropriate legal advice in connection with those contacts.

You should be aware that I may practice with other health professionals and that I may employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as typing, scheduling, billing, and quality assurance and you agree that I may do that. If I do that I will only release the information necessary in order for me to provide help to you, the client. All of the health professions will be bound by the same rules of confidentiality. All staff members will have been given training about protecting your privacy and will have agreed not to release any information outside of the practice without the permission of a professional staff member.

Also, I may have a contract with a collection agency. I will have a formal business contract with this business, in which it promises to maintain the confidentiality of this data except where release of certain information is allowed or is required by law.

In addition, I may have a contract with a billing service. I will have a formal HIPAA business associate contract with this business, in which it promises to maintain the confidentiality of this data except where release of certain information is allowed or is required by law.

This summary is designed to provide an overview of confidentiality and its limits. It is important that you read the Notice of Privacy Practices form that has been provided to you for more detailed explanations, and that you discuss with me any questions or concerns that you have.

***Legal Situations***

If you or the client (if the client is a minor or a ward of a guardian) become involved in legal proceedings that require my participation you will be expected to pay for all of my professional time, even if I am called to testify by another party. I will ask that a retainer be paid of half of the expected fees at least one week prior to providing these services, and the second half of expected fees and any additional fees that may have been accrued be paid within one week after services are delivered. Any unused amounts will be refunded. My professional time for legal proceedings may include preparation (document review or letter preparation), phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time that I wait in court prior to or after I may be called to testify). Due to the time-consuming and often difficult nature of legal involvement, I charge $150.00 per hour for these services. You will also be responsible for any legal fees that I may incur in connection with the legal proceeding, which may include responding to subpoenas.

Please be advised that as a treating therapist I cannot ethically provide any recommendations on guardianship, custody, visitation, parenting capacity or abilities or what is in the best interest of the child(ren) if you or your child(ren) are involved in custody/divorce/guardianship proceedings.

***Professional Records***

The laws and standards of my profession require that I keep Protected Health Information about you in your client file. Your client file may include information about your reasons for seeking therapy, a description of the ways in which your problems affect your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of all of your records that I have prepared in connection with your treatment if you request them in writing, unless I determine for clearly stated treatment reasons that disclosure of the records to you is likely to have an adverse effect on you, and in that event under Ohio law I may exercise the option of turning the records over to another mental health therapist designated by you, unless otherwise required by federal law. Because these are professional records they can be misinterpreted and/or upsetting to untrained readers, I therefore recommend that you initially review them with me, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge fees set under Ohio and federal laws for copying and sending records. These fees may change every year, so I will let you know what the charge is at the time that a records request is made. If you desire to have the information sent to you electronically, if I maintain the information in an electronic format, I will provide the information in that format if you agree to accept the potential risks involved in sending the information that way.

As your therapist, I may also keep a set of psychotherapy notes which are for my own use and which are designed to assist me in providing you with the best treatment. These notes are kept separate from the rest of your records. In order for psychotherapy notes to be released to third parties, you must sign a separate authorization in addition to one for the rest of your records. I will discuss with you whether or not I am maintaining psychotherapy notes on you.

***Fees, Payments, and Billing***

Payment for services is an important part of any professional relationship. This is even more true in therapy; one treatment goal is to make relationships and the duties and obligations they involve clear. You are responsible for seeing that my services are paid for. Meeting this responsibility shows your commitment and maturity.

My current regular fees are as follows. You will be given advance notice if my fees should change. Regular therapy services are $130.00 for the first diagnostic session as well as for subsequent 60-minute sessions for individual and couples therapy, $270.00 per 90-minute family sessions (3-6 people), with 6 session packages available for $645 for individual or couples therapy and $1375.00 for family therapy. A refund of all or a portion of unused prepaid sessions will be considered if I determine there was a valid reason for cancelation, otherwise they are non-refundable and unused sessions expire 6 months after the date of the last session date. This is to encourage your active participation in therapy on a continuing basis. Please pay for each session before or at its end. Sessions can also be paid for online when the appointment is scheduled. I have found that this arrangement helps us stay focused on our goals, and so it works best. It also allows me to keep my fees as low as possible because it cuts down on my bookkeeping costs. I suggest you make out your check before each session begins, so that our time will be used best. I also take cash, credit card (Visa, Mastercard, AMEX, and Discover), as well as Health Savings account payments. Other payment or fee arrangements must be worked out before the end of our first meeting.

Telephone consultations: I believe that telephone consultations may be suitable or even needed at times in our therapy. If so, I will charge you my regular fee, prorated for the time needed. If I need to have long telephone conferences with other professionals as part of your treatment, you will be billed for these at the same rate as for regular therapy services. If you are concerned about this, please be sure to discuss it with me in advance so we can set a policy that is comfortable for both of us. Of course, there is no charge for calls about appointments or similar business issues.

Extended sessions: Occasionally it may be better to go on with a session, rather than stop or postpone work on a particular issue. When this extension is more than 10 minutes I will tell you, because sessions that are extended beyond 10 minutes will be charged on a prorated basis.

If you think you may have trouble paying your bills on time, please discuss this with me. I will also raise the matter with you so we can arrive at a solution. If your unpaid balance reaches $300.00, I will notify you. If it then remains unpaid, I may stop therapy with you if we cannot agree on a payment plan. Fees that continue unpaid after this may be turned over to small-claims court or a collection service and you agree to allow me to do that. If I choose to do that I will report only enough information to collect fees due to me.

A late payment fee of $25.00 will be charged each month that a balance remains unpaid, since I will incur costs to rebill and other accounting costs. A returned check fee of $35.00 will be charged if your check bounces.

***Minors***

If you are under 18 years of age, please be aware that the law generally provides your parents the right to examine your treatment records, unless blocked by court order or if I feel that the release of your records to your parents might have an adverse effect on you, in which case under Ohio law they can name another mental health therapist that I will have to turn them over to, unless otherwise required by federal law. Before giving parents any information I will discuss the matter with you, if possible, and do my best to handle any objections you may have. Except in unusual circumstances, I like to make both parents aware of and involved in the treatment. In addition, if one parent brings in a child and the therapy only involves the child, under Ohio law since generally both parents have access to the child’s records unless that access is blocked by a court order, anything that either parent says in the sessions is available to both parents. Legal documents need to be provided in cases where custody, visitation, shared parenting, guardianship or other matters which are covered by court documents are involved before I see a minor for treatment. Minors 14 years of age and older should be aware that they have an option to see me on a limited basis without their parents’ knowledge, except where there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of my intent to inform the minor’s parent, or guardian. Only the minor is responsible for paying for services under this option.

***Emergencies and After-Hours Care***

I may be reached at (513) 294-8114. I will make every effort to return messages within 24 hours; however, I may not always be able to do that. Current clients will be notified during sessions of upcoming travel or vacation. If you have an emergency you should go directly to a hospital emergency department or call 911. The National Suicide Prevention Lifeline number is 1-800-273-8255. Emergencies are urgent situations and require your immediate action.

***Incapacity or Death of Therapist***

In the event that I am incapacitated or die, it will be necessary for another therapist to take possession of your file and records. By signing this form you consent to allow another licensed mental health professional whom I designate to take possession of your file and records, provide you with copies upon request, or to deliver them to a therapist of your choice.

***Disclosing Information to Family Members, Relatives, or Close Friends***

\_\_\_\_\_\_By initialing this section you agree to allow me, if you are incapacitated, in an emergency situation, or are not available, to contact a family member, a relative, a close friend or any other person you identify, and disclose your personal health information that directly relates to that person’s involvement in your healthcare. This information will be disclosed as necessary only if I determine that it is your best interest based on my professional judgment.

***Email, Texting, and Electronic Communications***

I do not like to use e-mail, texting, or electronic communications unless we both agree that is appropriate. If you decide you want to utilize any form of electronic communication you acknowledge that there are confidentiality risks inherent in such communications if they are unencrypted and you agree to accept those risks. If you wish to use unencrypted electronic communications, please place your initials in the space below:

\_\_\_\_\_\_By initializing this section you agree that you understand the risks involved in unencrypted electronic communications and agree to accept such risks in communications from either me to you or you to me that involve scheduling and/or therapy.

If you do not want me to contact you at a certain address or phone number, please let me know at our first meeting.

\_\_\_\_\_\_ (Please initial if you wish to opt out) Labors of Love sends occasional email communications regarding new services, promotions, and mental health related information. All clients are automatically added to the Labors of Love email list. If you do not wish to receive these notifications, please initial at the beginning of this section.

***Acknowledgment of Informed Consent to Treatment***

**I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize you to provide such care, treatment or services as are considered necessary and advisable.**

**I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through you at any time. I also understand that there are no guarantees that treatment will be successful.**

**By signing this Acknowledgment of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor is the client I am signing on behalf of the minor as the authorized parent/guardian. (Information on Minor rights will be shared with the minor)**

**I also acknowledge that I have received a copy of the Notice of Privacy Practices for the mental health therapist listed at the top of this form.**

**Client Name(s)** (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client(s) Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

**Parent(s) or Guardian Signature** (for minor child or children or disabled adults) 



969 Reading Rd. Suite E, Mason, Ohio 45040 Ph: (513) 294-8114

**ELECTRONIC SERVICE DELIVERY INFORMED CONSENT**

Electronic Service Delivery is defined as mental health therapy in any form offered or rendered primarily by electronic or technology assisted approaches when the mental health therapist and the client are not located in the same place during delivery of services. While working with me you will always have the opportunity to ask any questions that you have about the therapy, electronic communications in general, and other issues involving my therapy with you. I will also assess your ability to handle computers and the internet, so that we may work in this way.

As a client receiving mental health services through electronic service delivery methods, you should understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email) and may or may not involve direct, face to face, communication. There are benefits and limitations to this service. You will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information may not be direct, and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery. I will assess whether or not therapy through means of electronic service delivery is appropriate for addressing your issues and whether or not you have the knowledge and skills to use the technology involved.
2. As a therapist licensed in Ohio, I may only deliver services to residents or people located in Ohio. If you plan on leaving Ohio for any length of time in the future, please let me know as soon as possible so that we can make proper arrangements for future work or referrals, as appropriate. If you are going to be out of state during therapy, then I will have to comply with the licensing laws of the state where you will be located.
3. If a need for direct, face to face services arises, it is your responsibility to contact providers in your area, or to contact this office for a face to face appointment. You understand that an opening may not be immediately available.
4. You may decline any electronic service delivery service at any time without jeopardizing your access to future care, services, and benefits.
5. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet or through other electronic services that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. You and I will regularly reassess the appropriateness of continuing to deliver services through the use of technology. When using these services, you agree to accept the risks involved with the unencrypted exchange of information, if it is provided in that way.
6. I will need to verify your identity in a face to face meeting, which may be via video/audio electronically and then verify your identity in subsequent sessions. At the initial session we will address imposter concerns. You should be aware that misunderstandings are possible with telephone, text-based modalities (e.g., email), and real-time internet chat, since non-verbal cues are relatively lacking. Even with video chat software, since bandwidth may be limited and images may lack detail, misunderstandings may occur. I am an observer of human behavior. I will gather information from your body language, vocal inflection, eye contact, and other nonverbal cues. Cultural differences and how they affect non-verbal cues may also be involved and I will assess whether or not this type of therapy is appropriate for your cultural experiences, your specific therapeutic issues and your environment. If work is being done with families or groups with different levels of technology competence, power dynamics will be acknowledged. Please let me know if you have any type of audio/visual or cognitive impairment prior to beginning therapy. If you have never engaged in online counseling, you need to have patience with the process and request clarification if you believe that you are not being understood by me or you do not understand something that I say. I will regularly review whether or not electronic service delivery is meeting the goals of therapy. I will also discuss with you how to handle disruptions in services and will discuss with you all methods of delivering services that are compliant with commonly accepted standards of technology safety and security at the time at which services are rendered.
7. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:
8. In emergency situations: If it is an imminent situation that requires face-to-face contact call 911 or go to the nearest emergency room. If it can be managed over the phone, you can call me but if I do not respond immediately or within a short period of time, you should contact local emergency services (for example, call 911 or go to your local hospital’s emergency room, or call the National Suicide Prevention Hotline number -1-800-273-8255.) Also, other local hotline crisis phone numbers may be available to call, and you can check on the internet to find those.
9. Should service be disrupted: Try to regain contact using the same medium. If that does not work, attempt to make contact using text or e-mail. I will also make every effort to regain contact. If service is disrupted during a therapy session before the pre-agreed time frame has ended, you will have the opportunity to use the remaining time as soon as contact is made. If contact is not re-established within one hour, you will have the choice to end the session and be charged a pro-rated amount or allowed to schedule an additional session to use the remaining time.
10. For other communication: You and I may agree to communicate via a phone call, videoconferencing, e-mail, text, fax, or mailed letters.
11. The potential benefits of online counseling include flexibility in scheduling and allowing you to engage in counseling outside of the office, which eliminates issues like transportation and other psycho-social barriers that might make it difficult for you to handle in a traditional office setting. The provision of online counseling may include risks related to the technology used, the distance between you and I, and issues related to timeliness. For example, the potential risk of confidentiality may pertain to your accessing the internet from public locations. You should consider the visibility of your screen and being overheard when in public settings. It is recommended that you be in a private setting when engaging in online counseling. You should also always use strong passwords to protect any information shared with me. Never use a work computer for therapy as your employer may have access to the information shared in electronic communications. Be cautious when using a shared network with others.
12. Although the internet provides the appearance of anonymity and privacy in counseling, privacy is more of an issue online than it is in person. You are responsible for confidentiality in your own environment, including securing your hardware, internet access points, chat software, email, and passwords. Please develop passwords that are appropriate and strong and not use auto-fill for user names or passwords. Although I will take steps to protect your information, I will have policies in effect to notify you of a breach of any of your confidential information which is required to be reported to you.
13. I may utilize alternative means of communication in the following circumstances: if you do not respond to text, I may attempt to call you. If you do not respond to a call, I may follow up with text or e-mail. If you do not respond to a call, text, or e-mail, I may follow up with a mailed letter. In case of emergency (or concerns over your welfare), I may contact your emergency contact if you have provided one.
14. I will attempt to respond to communications and routine messages within 48 hours if I am available.
15. It appears that most Ohio insurance companies are reimbursing for telehealth sessions. However, you should check with your insurance company to determine if they will reimburse you for electronic service delivery sessions. If insurance does not cover reimbursement, then you agree to pay the fee for the service.
16. You need to take the following precautions to ensure that your communications are directed only to me or other individuals: Ensure that you use the correct e-mail address, telephone number, skype or online name, fax number, and physical address to contact the appropriate individuals. Only leave voice messages after ensuring that the correct phone number was dialed and the voicemail introduction identifies the correct individual.
17. Your communications exchanged with me, if capable of being put into written form, will be stored in the following manner: e-mails, texts, and other electronic communication relevant to treatment will be printed and kept in your file. Mailed letters and documents will also be kept in your file. Notes outlining electronic service delivery treatment sessions will be written and kept in your file. Your file will be kept in a locked file cabinet or stored electronically and will be accessible only by those who require or are allowed access and will be available to you or someone named by you for the length of time required under Ohio law. I will not record sessions without first discussing it with you and obtaining your permission to do that. Please see my regular Informed Consent form for information on access to your records, including who will have access to them.
18. The laws, ethics, and professional standards that apply to in-person therapeutic services also apply to services delivered by electronic means. This document does not replace other agreements, contracts, or documentation of informed consent covering other issues. If you want licensing information on me or other information regarding professionals with my license, you can find it at [http://cswmft.ohio.gov/,](http://cswmft.ohio.gov/) the Counselor, Social Worker & Marriage and Family Therapist Board’s website.

**Acknowledgment of Informed Consent to Treatment via Electronic Service Delivery Means**

***You voluntarily agree to receive mental health assessment, care, treatment, or services and authorize me to provide such care, treatment or services as are considered necessary and advisable via electronic service delivery means.***

***By signing this Electronic Service Delivery Informed Consent, you, the undersigned client, acknowledge that you have both read and understood all the terms and information contained herein and you agree to be bound by the provisions in this agreement. Ample opportunity has been offered to you to ask questions and seek clarification of anything unclear to you. If a minor is the client, you are signing on behalf of the minor as the authorized parent/guardian. (Information on Minor rights will be shared with the minor if they are old enough to understand this information)***

***You also acknowledge that you have received a copy of the regular Informed Consent and Notice of Privacy Practices for my practice.***

**Client Name(s) (please print)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client(s) Signature(s)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Parent(s) or Guardian Signature (for minor child or children or disabled adults)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Printed Name**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ **Date**

**Signature of Parent or Legal Guardian**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ **Date**

**Signature of Other Parent**