Northeast Youth & Family Services
Transforming Lives

REQUIRED SIGNATURES - 2020

CLIENT NAME: _____ **CLIENT DOB**: _____

If client is a minor, please print name of parent/guardian signing on behalf of the client:

_____ _____

(PRINT PARENT/GUARDIAN NAME) (RELATIONSHIP TO CLIENT)

If client is under 18, do you have legal custody of the child? (circle one) YES NO

If NO, please list legal guardian/parent and phone number: _____
(Legal documentation, such as legal guardianship paperwork, divorce decree, etc., must be provided to the clinic if requested)

FINANCIAL POLICY / MISSED APPOINTMENT POLICY & IMPORTANT INFORMATION POLICY

My signature below indicates that I have been provided with a copy of the **Financial Policy and Missed Appointment Policy**. I understand that I am financially responsible for all appointments, unless cancelled with at least 24 hours notice; a charge of **$50.00 per scheduled appointment** will be applied to my account.

ASSIGNMENT OF BENEFITS **Please initial: _____**

I hereby authorize direct payment to Northeast Youth & Family Services of any medical benefits otherwise payable to me for services provided by a therapist or psychiatrist affiliated with Northeast Youth and Family Services.

RELEASE OF MEDICAL INFORMATION **Please initial: _____**

I hereby authorize Northeast Youth & Family Services to release my records to my insurance company for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payer.

NOTICE OF PRIVACY PRACTICES **Please initial: _____**

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices.

CONTACT INFORMATION **Please initial: _____**

Northeast Youth & Family Services considers your email address and other contact information to be confidential and will not disclose it to outside entities, including email communication between client and therapist. You are responsible for notifying NYFS if your demographic information changes at any time during your tenure as a client at NYFS.

NORTHEAST YOUTH & FAMILY SERVICES CLINICAL & BUSINESS STAFF RELEASE **Please initial: ____**

Northeast Youth & Family Service staff are involved in my care, and adhere to the HIPAA Policy. I authorize the release of minimal records necessary for provision of care within NYFS.

The above forms have been read by me and I have been given an opportunity to ask questions about them.

_____

(Signature of Patient/Client or Personal Representative) Date