

# FAMILY

## THERAPY ASSOCIATES, LLC

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715-246-4840 Fax: 715-254-9459  
[www.ftacounseling.com](http://www.ftacounseling.com)

### CHILD INFORMATION AND RELEASE TO BILL INSURANCE

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PRIMARY PHONE: \_\_\_\_\_

ADDITIONAL PARENT/GUARDIAN NAME: \_\_\_\_\_

PRIMARY PHONE: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_

Family Therapy Associates is able to send appointment reminders to your email address or as a text message to your mobile phone (if you have texting capability; available for most cell phone providers). Please be aware of any costs associated with texting to your mobile phone - check with your mobile service provider if you have questions before agreeing to receive text messages.

An email or text message would arrive to your email or phone from [info@ftacounseling.com](mailto:info@ftacounseling.com) and would include the client's name, date and time of appointment, and the name of the provider you will be seeing.

I authorize Family Therapy Associates to send appointment reminders as follows (**PLEASE CHOOSE ONE:**)

\_\_\_ To the following email address:

OR

Initials: \_\_\_\_\_

\_\_\_ To the following cell phone number as a text message:

OR

\_\_\_ Via call to the following number

\*Please let us know if any of this information changes to ensure message deliver.

1.) I authorize the release of all information obtained by Family Therapy Associates, LLC to my referring doctor or funding source and I authorize payment from my funding source for services rendered to Family Therapy Associates, LLC.

2.) I understand that I am responsible to pay for services that are not paid by my insurance policy, include all co-payments and deductibles. I agree that any outstanding charges may be submitted to the client credit/debit card on file and copy of receipt will be mailed to me along with an invoice should this occur.

**3.) I certify that I have the legal authority** to consent for mental health services for this minor child/adolescent.

**4.) I recognize that this therapy will not yield** considerations about custody and that my child/adolescent's therapist cannot side with familial disputes or make recommendations regarding custody. I understand that my child/adolescent's therapist does not testify in court and I agree that if his or her therapist is called to testify, it will not be in my child/adolescent's best interest as my child/adolescent's counseling may suffer as a result.

**I certify this information is true and correct to the best of my knowledge and I agree with points 1 through 4 on this consent form.**

**Client Signature: (age 14 and up)** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_