FAMILY

THERAPY ASSOCIATES, LLC

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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 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: _____