Office Use Only
Date Account Created: ___/___/____
Funding Source: _____

Client ID#: _____
Last Name: _____
Date Scanned to EHR: ___/___/____
Scanned by: _____

Administrative Office ● 2650 Olive Street ● Saint Louis, Missouri 63103 ● 314-371-6500

SCHOOL BASED SERVICES SIGNATURE PAGE

Please complete the following information about your child and sign below to allow your child to participate in therapy services provided by Provident staff at his or her school with no out-of-pocket costs to you.

Child's Name: _____ Age: _____ Home Phone: _____
First, Middle, and Last Name

Parent's Name(s): _____ Parent's Work Phone: _____

Street Address: _____ Cell/Other #: _____

Apt #: _____ Child's Date of Birth: _____ Email: _____

City: _____ State: _____ Social Security #: _____-_____-_____

Zip Code: _____ Child's Gender: ☐ Male ☐ Female ☐ Other: _____

Race/Ethnicity: ☐ African American ☐ Caucasian ☐ Asian ☐ Native American/Alaskan Native
☐ Hispanic/Latino ☐ Biracial/Multiracial ☐ Other: _____

Child's Sexual Orientation: ☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Questioning

Annual Family/Household Income: $_____ Total # of people living in household: _____

Name of Child's School: _____ Who referred you to Provident? _____

What problems or concerns is your child experiencing? _____

_____

What do you hope to for your child to accomplish by participating in services provided by Provident?

_____

_____

Consent to Treatment

I understand that my child may receive education, prevention, and counseling services from Provident as part of my child's school's menu of services. I have the right to be informed my child's treatment and progress. I understand that there are both risks and benefits associated with services. I understand that I may stop services at any time. I understand that Provident agency staff may terminate services if the needs of my family or my child cannot be met. I understand that agency staff will provide a referral to an appropriate alternate provider should this occur.

Statement of Confidentiality

I understand that information about my child's treatment is confidential. However, due to the nature of school based counseling services, information about my child's treatment may be shared with necessary school staff to meet my child's needs. Provident assures all clients of our commitment to maintain the highest degree of confidentiality possible.

Client Rights and Responsibilities

I have the right to be treated with respect, to be provided with informed consent, and to be treated by professionals who uphold the highest ethical standards. I have the responsibility to provide accurate and complete information related to treatment services and to follow the treatment plan developed.

Notice of Privacy Practice

Provident has adopted its Notice of Privacy Practice policy to comply with the HIPAA, HITECH, the Omnibus Rule, and the Department of Health and Human Services ("DHHS") security and privacy regulations.

Client Fee Information

Children residing in St. Louis County are provided services with no out of pocket costs from Provident via the Children's Service Fund grant. Children residing within St. Louis City limits or residing outside of St. Louis County may also have funding available to provide these services at no cost to you. Please contact Provident staff or your child's school to determine how fees will be paid for services provided by Provident in the school.

For a complete copy of Provident's Policies, please ask Provident staff or locate online at:
http://www.providentstl.org/Services/IndividualandFamilyCounseling.aspx

I agree to the terms of the Consent to Treatment, Statement of Confidentiality, Client Rights and Responsibilities, Notice of Privacy Practice, and Client Fee Information. I request services from Provident.

Client/Guardian Signature(s): _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____