Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

SCHOOL BASED SERVICES SIGNATURE PAGE

Please complete the following information and sign below to allow your child to participate in services provided by Provident Behavioral Health staff at your child's school with no out-of-pocket costs to you.

Child's Name: ___________________________________ **Birth Date:** ____/____/________ **Age:** ______
First, Middle, & Last

Child's Nickname/Chosen Name: ___________________ Parent's Name(s): ____

Address: _____________________________ Apt #: ______ City: ______________________ State: _______ Zip: ___________

Home Phone: ______-______-________ Cell Phone: ______-______-________ Email: _______________________________

Provident may contact me and leave a message by (check all that apply): ☐ Voicemail ☐ US Mail ☐ Text Message
☐ **Please do not** contact me in the following ways: ___________________

In the case of any emergency, please notify: Name: _______________________ Relationship: _________ Phone: _____________

Sex at Birth: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Other: ________________

Race/Ethnicity: ☐ Black or African American ☐ Caucasian ☐ Asian ☐ Hispanic/Latino ☐ Biracial/Multiracial
☐ Native American or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Other/Describe: _______________________

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

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

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

Does your child have insurance? ☐ No ☐ Yes If yes, name of the Insurance Provider: _____________________

Please note: Provident will not bill your insurance provider without your consent. This information is for data collection purposes only. Insurance ID number is required to bill insurance.

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 I have chosen to participate in behavioral health services from Provident. I have the right to be informed my 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 my needs cannot be met. I understand that agency staff will provide a referral to an appropriate alternate provider should this occur.

Initial Here: _______

Statement of Confidentiality

I understand that information my treatment is confidential. However, there are some limitations of confidentiality which require the disclosure of information, including but not limited to: risk of harm to yourself or others, when mandated by law, collaborating with your treatment team, or when your insurance or funding source requires information regarding your care. Provident assures all clients of our commitment to maintain the highest degree of confidentiality possible.

Initial Here: _______

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.

Initial Here: _______

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.

Initial Here: _______

Client Fee Information

Children residing in St. Louis County or attending St. Louis County Schools are eligible for services with no out of pocket costs thanks to funding from the Children's Service Fund. 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.

Initial Here: _______

For a complete copy of Provident's Policies, please ask Provident staff or locate online at:
https://www.providentstl.org/counseling/individual-counseling/

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:** _______________