



1469 SOUTH MAIN ST
NORTH CANTON, OH 44720
330.499.3065 FAX: 330.499.2497

Initial Date of Contact: _____

Counselor: _____

Appointment Date & Time: _____

CHILD/ADOLESCENT CONFIDENTIAL INFO & CONSENT TO TREATMENT 2022: (PLEASE PRINT)

Name of child: _____ Age: _____ Gender: _____
Last First Middle

Home address: _____
Street City State Zip

Birthdate: _____ Preferred Phone: _____

*May we leave a text or voicemail? Yes No

Grade: _____

School: _____

Custody Agreement: Yes No **If yes, must be provided BEFORE appointment.*

Primary Doctor: _____ Practice Name: _____

**Are you willing to sign a form to release information to coordinate treatment with your Primary Care Physician?*

Yes No

Parent Legal Guardian Relationship: _____

#1 Parent /Legal Guardian Name: _____ Birthdate: _____

Address (if different from above): _____

Phone: _____ E-mail: _____

#2 Parent Name: _____ Relationship: _____

Address (if different from above): _____

Phone: _____ Birthdate: _____

Handicapped Access Required? Yes No (**Not all facilities have wheelchair accessibility.*)

_____ Initials I have been given access to the HIPAA Privacy Practices and have the right to request a paper or electronic copy for my personal use.

_____ Initials I consent to allow The Gentle Shepherd Counseling Center to use unsecure email to transmit protected health information (PHI). I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my PHI by unsecured means.

I hereby authorize treatment with The Gentle Shepherd Counseling Center. All information provided above is accurate. I agree to payment of all charges accrued.

Date: _____ Name: _____

Client Name: _____ DOB: _____

Counselor: _____

HOW CAN A COUNSELOR BEST HELP YOU?

PREFERENCES / REQUESTS: *Cannot guarantee all requests (ie. clinician, day or time)

How did you hear about us: _____

Self Pay (Each visit at \$150) *Optional sliding fee scale based on qualifications, documentation required

Household Annual Salary: _____ Number of Dependents: _____

Insurance (Aetna, Anthem, Aultcare, Cigna, Med Mutual, Mutual Health, The Health Plan, Ohio Health Choice, PHCS, UBH, Optum, UMR, Summa*) ****some plans accepted*** NO MEDICARE/MEDICAID

Insurance Company: _____ Policy Holder: _____

Member ID: _____
Group Number: _____

Person responsible for payment: _____ Phone: _____

Address (if different from above): _____

Benefits (for office use only)

Date: _____

Staff Initials: _____

Insurance Pays: _____

Copay: _____

Deductible: _____

Deductible Met: YES NO

Out of Pocket: _____

Out of Pocket Met: YES NO