The Gentle Shepherd COUNSELING CENTER

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

Initial Date of Contact: _____

Counselor: _____

Appointment Date: _____

Appointment Time: _____

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

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

Home address: _____
Street City State Zip

Birthdate: _____ Phone: Home _____ Cell : _____

*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: _____ E-mail: _____

☐ Insurance/ EAP 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: _____

Employer: _____ Employer Phone: _____

☐ Self Pay (1st visit $150 due at visit, each addt'l visit $125) *Optional sliding fee scale based on qualifications, documentation required

Household Annual Salary: _____ Number of Dependents: _____

REASON FOR COMING:

_____

_____

_____

PREFERENCES / REQUESTS: * New client scheduling may depend on requests (ie. clinician, day or time)

_____

_____

_____

How did you hear about us: _____

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

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 hereby authorize treatment with The Gentle Shepherd Counseling Center. All information provided above is accurate. I agree to payment, of any and all charges accrued, not to exceed twenty five (25) days following date of service.

Date: _____ Signature: _____

Office Staff: _____