Today’s Date \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Client’s Last Name | First Middle | Birth Date Age Gender **M F** |
| Parent/Legal Guardian 1 Last Name | First | Best Contact # for Parent/Guardian 1( )  |
| Parent/Legal Guardian 2 Last Name | First | Best Contact # for Parent/Guardian 2( )  |
| Client’s Home Street Address | Client Lives With | Client’s Cell Phone( ) |
| City | State Zip Code | Client’s Home Phone( ) |
| Current School/Academic Setting | Current Grade or Last Grade Completed <> | Client’s Email Address |
| Referred to Jon Schoonmaker by: |  |  |

|  |  |  |
| --- | --- | --- |
| **IN CASE OF EMERGENCY** |  |  |
| Name | Relationship to Client | Best Contact Number |
|  |  |  |
|  |  |  |

Parent /Guardian, please read carefully and sign below.

I hereby provide consent for Jon Schoonmaker to bill my insurance for all appropriate services provided to my child. I understand that protected health information may be shared with my insurance provider.

Please indicate your insurance provider: \_\_\_\_\_ BCBS of Michigan \_\_\_\_\_ Meridian

If Medicaid or BCBS are not being billed for services, I understand that I am responsible for payment of fees at the time of each appointment. I agree to be responsible for payment of fees for services rendered regardless of whether private insurance reimbursement will be sought.

I hereby consent to counseling for my child by Jon Schoonmaker, LPC. I understand that I have a right to refuse or discontinue treatment for my child at any time. I understand that I am responsible, however, for any balance due prior to a decision to discontinue.

X
 Signature of Parent or Guardian Date