

OTHER CONTACTS (OTHER PARENT, SPOUSE, LEGAL GUARDIAN OR CAREGIVER)

Please list other individuals who are involved in taking care of the patient, such as spouse or caregiver, with whom you authorize Family Achievement Center to discuss the patient's treatment.

NAME: _____
LAST FIRST MI

RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: (____) _____ EVE PHONE: (____) _____ CELL PHONE: (____) _____

Name of Emergency contact who can be called in the event that the primary parent/caregiver is not available:

NAME: _____
LAST FIRST MI

RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: (____) _____ EVE PHONE: (____) _____ CELL PHONE: (____) _____

HOW DID YOU HEAR ABOUT US? Phonebook ___ Website ___ Friend ___ Dr ___ Other _____

AUTHORIZATIONS and ACKNOWLEDGEMENTS

I have received the Notice of Privacy Practices from Family Achievement Center, Inc.

SIGNATURE: X _____ DATE: _____
Parent/Legal Guardian

I authorize Family Achievement Center to add my name to their emailing list to notify me of upcoming programs, workshops, special events. *This email list is kept private and will not be sold or distributed to anyone outside of the clinic.* Yes _____ No _____

Email address: _____

I hereby authorize FAMILY ACHIEVEMENT CENTER to furnish information concerning my illness and treatments to INSURANCE CARRIERS, PHYSICIANS, THERAPISTS, AND/OR OTHER PERSONNEL, who are involved in taking care of the patient. I authorize payment of any medical benefits to FAMILY ACHIEVEMENT CENTER. **I certify that the above information is correct and that I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED.** I permit a copy of this authorization to be used in place of the original.

SIGNATURE: X _____ DATE: _____
Parent/Legal Guardian

THANK YOU!