



Group Participant Information Form- 2017

Please read the following information, answer the applicable questions, and sign and date below.

Child Name: _____ Child Date of Birth: _____

Patient Information

Parent(s)/ Legal Guardian Name(s): _____

Street Address: _____

City/ State/ Zip: _____

Phone: Home: _____ Cell: _____ Work: _____

Primary Email: _____

Known Allergies of the Child (bee stings, medications, hay fever, asthma etc. Please list severity of condition and how it is controlled e.g., ice, or with prescription over the counter medications):

Food or Dietary Restrictions (list food allergies, reaction to food, and any treatment used. Also list any religious restrictions, vegetarian requirements) _____

Religious/Cultural Restrictions (e.g., are there any holidays or topics that you prefer we do not discuss during groups?) _____

Child's Nickname: _____

How did you hear about our Groups? _____

Other/ Special Requests: _____

Funding Information

____ Delaware County Board of Developmental Disabilities Funds- Payment Authorization for Services (PAS) will be required.

____ Self-Pay

____ Other: _____

Emergency Information

Emergency Contact 1: _____ Phone: _____ Relationship: _____

Emergency Contact 2: _____ Phone: _____ Relationship: _____

Physician Name: _____ Physician Phone: _____

Physician Address: _____

Preferred Hospital in Case of Emergency: _____

In Case of Emergency and parent is not present, do we have permission to transport to the hospital? ____ YES ____ NO

Please Indicate in Which Group(s) you are Enrolling:

I attest by signing below that the above information is true and accurate. I authorize Flourish Integrated Therapy, LLC to administer treatment and bill and release required information to my funding source for services rendered.

Signature of Person Filling out this Form: _____

Printed Name of Person Filling out this Form: _____

Relationship to Client: _____ Date Form Completed: _____





PATIENT CONSENT FORM- 2017

Client Name: _____

Client Date of Birth: _____

Flourish Integrated Therapy, LLC does not discriminate against any person on the basis of race, color, national origin, disability, gender, age or handicap in admission, for treatment, or participation in its programs, services and activities, or in employment. For further information about this policy or questions or concerns, please contact: Kimberly Martin at Flourish Integrated Therapy, LLC by phone at 614.545.8300 or by email at info@flourishohio.com

Please read the following information, indicate yes or no on each line to indicate your preference, and sign and date below.

Do you give consent for you/ your child to receive services through Flourish Integrated Therapy, LLC?

_____ YES _____ NO

At times, Flourish Integrated Therapy, LLC will seek out clients willing to participate in multi-media marketing efforts, which may include, but not be limited to, photos, videos, quotes, names for use on marketing fliers/ announcements, websites, In-Clinic use, etc..

Do you give consent to Flourish Integrated Therapy, LLC to utilize you/ your child's information (could include first name and last initial only) for marketing purposes?

_____ YES _____ NO

At times, group instructors will take photos during the group sessions to share on the Flourish Facebook page for parents/caregivers to enjoy. Do you give consent to Flourish Integrated Therapy, LLC to post your child's photo on our Facebook page?

_____ YES _____ NO

At times clients participate in 1:1 speech-language therapy or occupational therapy to enhance their group experience. Would you like to be contacted about individual services?

_____ YES _____ NO

If you enroll in a group program but choose to withdraw after the first session there will be a \$35 fee for attendance. After the 2nd session no refund will be given. Missed sessions will not be prorated. This policy MUST be followed for our groups to run effectively.

In order to ensure the safety of your child, it is imperative that a supervising and authorized adult be present in the building at all times and that a current emergency contact be provided. Flourish Integrated Therapy, LLC will not be held liable for injuries or accidents sustained as a result of lack of supervision outside of the therapist's care. Flourish Integrated Therapy, LLC will make all attempts to provide a safe atmosphere and snack choices throughout the class series. It is the responsibility of the parent to notify us of medical changes, dietary needs and allergies.

I have been made aware of the policies and procedures for Flourish Integrated Therapy, LLC's group class series and agree to them effective immediately.

Signature of Person Filling out this Form: _____

Printed Name of Person Filling out this Form: _____

Relationship to Client: _____ Date Form Completed: _____

