Group Participant Information Form- 2019

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: ____
Current Concerns/ Goals: ____

____

Funding Information

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

Emergency Information

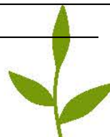
Emergency Contact 1: _______________________________ Phone: ________________________ Relationship:__________________
Emergency Contact 2: _______________________________ Phone: ________________________ Relationship:__________________
Physician Name: ____ Physician Phone: ______________________________
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- 2019

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**: _________________________