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www.lighthousecfs.com

CLIENT INFORMATION AND CONSENT

Client Legal Name: _____ DOB: _____

Preferred Name: _____

Legal Guardian Name*: _____ DOB: _____

Street Address: _____ City/State: _____ ZIP: _____

Phone: _____ Email: _____

Emergency Contact Name: _____ Phone: _____

**A copy of a divorce decree or other legal documents (i.e., custody agreements, restraining orders) may be requested by your provider or administrate staff as it may pertain to your child's mental health care. Please notify your provider or administrative staff of any court orders or legal documentation which may affect whoever has the right to consent for services for your minor child.*

CONSENT: *By signing this form, you are acknowledging the following agreements with Lighthouse Child and Family Services, Inc. (LCFS):*

1. I have been offered and/or have received a copy of LCFS's Office and Financial policies, Notice of Privacy Practices, Bill of Rights and Grievance Procedures. I understand my rights, including those related to confidentiality and its limitations.
2. I agree to all LCFS office and billing policies and consent for treatment of myself or my minor child by LCFS.
3. I authorize the release of any information, including medical and billing information, by LCFS to my referring doctor, insurance company, contracted billing company with LCFS, the responsible party named above, and immediate family on behalf of myself and/or dependents.
4. I authorize payment of medical benefits by my insurance company to LCFS for services rendered to myself and/or dependents. I understand it is my responsibility to notify LCFS if my insurance changes or is no longer active.
5. If applicable, I give consent for my minor child to receive therapeutic services in my presence or in my absence, at school or any other mutually agreed upon location.
6. If I am receiving services from a program that is partially funded by MN DHS, I consent for LCFS to share necessary data with DHS for reporting purposes.
7. I give my informed consent to participate in the use of telehealth services for treatment. With my signature, I consent to engaging in telehealth mental health services, when needed and appropriate.

Day Treatment Program Only: I confirm I have received and reviewed the Day Treatment Program Manual and understand and agree with the policies, procedures and conduct of behavior expected of me as a parent/guardian and of my child in the Day Treatment Program. *Initial here* _____

Appointment Reminder by Text: I request to be notified of my upcoming appointments by text message. I agree to pay the standard text messaging rates for this service, if applicable. *Initial here* _____

Physician Release: Mental Health Professionals are required to attempt to coordinate services with Primary Care Physicians (PCP). Please indicate an option:

___ I have no current PCP OR I do NOT currently authorize the release of information to/with my PCP.
___ I authorize the release/exchange of clinical and/or medical information with my PCP. ROI(s) will be completed at my appointment(s).

Health Care and Advance Psychiatric Directives (18 years and older): Do you have a Health Care Directive or an Advance Psychiatric Directive? Yes____ No____ If no, are you interested in receiving information regarding either? Yes____ No____

Medical Concerns: Do you have any medical concerns (including chronic or infectious diseases) of which we should be aware (influenza, seizure disorder, MRSA, tuberculosis, COVID etc.)? Yes____ No____ If yes, please list: _____

Please complete (for reporting purposes only):

Race: ☐ White ☐ Black/African Amer. ☐ Amer. Indian/Alaska Native ☐ Asian ☐ Other
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Both Hispanic and Non-Hispanic
Spoken Language: ☐ English ☐ Other: _____

X_____ X_____
SIGNATURE OF CLIENT/LEGAL GUARDIAN **DATE**