



## **Welcome to Arizona Children's Group!**

The staff and the executive team at Arizona Children's Group are committed to changing futures and changing lives. Personal growth and development can be one of the most difficult things we can do in life, especially as adolescent youth. Our program will provide a safe and supportive environment that will help your child aid in their personal development and continue on the journey to healing, one step at a time.

### **New Client Paperwork**

Please complete the attached forms and return them to the facility within 48-hours of admission. Attached within the New Client Paperwork Packet you will find:

1. Client Information Page
2. Payment Policy Agreement
3. Adolescent Data Sheet
4. Parent Form for Adolescent
5. Consent and Agreement for Treatment (Minor)
6. Consent and Agreement for Treatment (Guardian)
7. Consent and Agreement for Treatment (Consent for Minor)
8. HIPAA Release Form
9. Consent and Agreement for Education Enrollment

### **Privacy Notice Information**

The Privacy Notice of Arizona Children's Group is available online at [www.arizonachildrensgroup.com](http://www.arizonachildrensgroup.com) and available at each of the Arizona Children's Group offices across the Valley.



## CLIENT INFORMATION

Name: _____	Date of Birth: _____
Address: _____	City, State, Zip: _____
Primary Phone Number: _____	Okay to leave a message? <input type="checkbox"/> Y <input type="checkbox"/> N
Social Security Number: _____	Gender: Male   Female
How did you hear about Arizona Children's Group? _____	

## PARENT/GUARDIAN INFORMATION

Your Name: _____	Date of Birth: _____
Address: _____	City, State, Zip: _____
Primary Phone Number: _____	Okay to leave a message? <input type="checkbox"/> Y <input type="checkbox"/> N
Are you the parent/legal guardian of this minor? <input type="checkbox"/> Yes   <input type="checkbox"/> No Other: _____	

## BILLING INFORMATION/RESPONSIBLE PARTY

Name: _____	Date of Birth: _____
Address: _____	City, State, Zip: _____
Primary Phone Number: _____	SSN: _____
Relationship to Client: _____	
*Any unresolved and/or unpaid balances will be sent to a collection agency in the event that payment arrangements are not initiated by the responsible party.	

## INSURANCE INFORMATION

<b>PRIMARY INSURANCE CARRIER</b>	
Insurance Company Name: _____	Ins. Plan Name: _____
ID Number: _____	Group Number: _____

<b>SECONDARY INSURANCE CARRIER</b>	
Insurance Company Name: _____	Ins. Plan Name: _____
ID Number: _____	Group Number: _____



## ASSIGNMENT & RELEASE

I select Arizona Children's Group ("ACG") as my provider of choice for my son/daughter. I hereby authorize payment for services to Arizona Children's Group. I represent that I have insurance coverage and do hereby authorize Arizona Children's Group to release and obtain all information necessary to secure payment of said benefits. I understand that I am financially responsible for all charges, whether or not paid by the insurance company. I authorize the use of my signature on all insurance submissions.

I acknowledge that ACG has made available to me the Privacy Notice of Arizona Children's Group online at [www.arizonachildrensgroup.com](http://www.arizonachildrensgroup.com) and it has been electronically provided to me.

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Signature of Client Parent/Legal Guardian

Printed Name

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Date

Relationship to Client

## PAYMENT POLICY AGREEMENT

- 1. Insurance co-payments are due at the time of service.
- 2. Payment is due upon receiving your monthly statement in the mail.
- 3. I understand that all charges are my responsibility to pay in the event of insurance Denial. I realize that in some cases, insurance coverage will not pay all required fees, and in the event that it is not covered, I am responsible for any part unpaid.
- 4. I understand that I am responsible to maintain my child's/children's active coverage at all times, while in the care of Arizona Children's Group. I understand that any lapse in coverage, or terminated coverage, could result in personal responsibility of all billing and charges for the length of the stay.

**I have read and understand the above policies and agree to abide by them. By signing this commitment form I am agreeing to be the person financially responsible for this client account.**

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Name of Client: \_\_\_\_\_

Date: \_\_\_\_\_



Date: \_\_\_\_\_

## Adolescent Data Sheet

*This form should be completed by the adolescent receiving care.*

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

What do you think the reason is that you are now staying in ACG? \_\_\_\_\_

Whose idea was it for you to come to ACG? \_\_\_\_\_

How do you feel with the decision to be here? \_\_\_\_\_

Have you had any of the following stressors in the past 30 days?: *(Please circle one)*

Conflicts with your family	Recent	Past
Parents Separated	Recent	Past
Parents Divorced	Recent	Past
Changed where I live	Recent	Past
Death of a family member	Recent	Past
Illness of a family member	Recent	Past
Personal Injury	Recent	Past
New Diagnoses Given	Recent	Past
New Medication Given	Recent	Past
Problems with friends	Recent	Past
Problems at School	Recent	Past
Victim of Assault	Recent	Past
Emotional/Verbal Abuse	Recent	Past
Other Concerns	Recent	Past

Do you have friend(s) who you really like and feel you can talk to? \_\_\_\_\_

Do you think that your parents listen to you and take your feelings seriously? \_\_\_\_\_

Do you have concerns about someone in your family that you need to discuss? \_\_\_\_\_

Have you had any fun during the past two weeks?  Yes |  No

What were you doing when you were having fun? \_\_\_\_\_



Below are some questions that will help us understand you better, please check anything that applies to you:

### Emotional Concerns

<input type="checkbox"/> I'm sad or unhappy most of the time <input type="checkbox"/> I cry a lot <input type="checkbox"/> I'm often tired or out of energy <input type="checkbox"/> At times I feel I have nothing to look forward to <input type="checkbox"/> I don't seem to care about much anymore <input type="checkbox"/> Things in my life are unfair <input type="checkbox"/> I have had thoughts of suicide or harming myself <input type="checkbox"/> I'm often angry (easily irritated) <input type="checkbox"/> I don't enjoy things that I used to <input type="checkbox"/> I often don't like going new places <input type="checkbox"/> I have a lot of arguments with peers <input type="checkbox"/> I have a hard time making decisions by myself <input type="checkbox"/> I'm afraid of many things <input type="checkbox"/> I worry a lot <input type="checkbox"/> I have stolen things <input type="checkbox"/> I like/need things to be perfect	<input type="checkbox"/> I often daydream or get distracted <input type="checkbox"/> I forget things <input type="checkbox"/> I'm not very confident in myself <input type="checkbox"/> I sometimes do things without thinking <input type="checkbox"/> I often don't finish things that I start <input type="checkbox"/> I'm easily bored <input type="checkbox"/> I prefer to be moving over sitting <input type="checkbox"/> I have a hard time concentrating <input type="checkbox"/> I get in trouble for talking back to adults <input type="checkbox"/> I break the rules at home (I disobey my parents) <input type="checkbox"/> I have been in trouble with the law <input type="checkbox"/> I have thought seriously about running away from home <input type="checkbox"/> I have had times I feel in a panic <input type="checkbox"/> I prefer to be by myself <input type="checkbox"/> I have cut myself or mutilated part of my body (i.e. pulled out my hair)	<input type="checkbox"/> Peers have been cruel to me in my life (i.e. teasing or bullying) <input type="checkbox"/> It's hard to trust other people <input type="checkbox"/> People say I'm bossy <input type="checkbox"/> I'm sensitive to criticism from others <input type="checkbox"/> I wish I had more friends; I'm lonely <input type="checkbox"/> Sometimes my looks bother me <input type="checkbox"/> I have questions about my sex or my physical development <input type="checkbox"/> I love to take extreme risks <input type="checkbox"/> I sometimes have thoughts I can't seem to stop <input type="checkbox"/> Sometimes I hear things or see things that others can't <input type="checkbox"/> I get so angry I have broken things <input type="checkbox"/> I check/do certain things over and over <input type="checkbox"/> I like to set fires <input type="checkbox"/> I have experienced abuse from someone (emotional, physical, sexual)
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### School Concerns

<input type="checkbox"/> Other people are disappointed with my grades <input type="checkbox"/> School work is difficult for me <input type="checkbox"/> I get in <i>some</i> trouble at school (i.e. teachers talk to me or detention)	<input type="checkbox"/> I have been in <i>significant</i> trouble at school (i.e. suspension) <input type="checkbox"/> I hate going to school <input type="checkbox"/> I have often skipped school <input type="checkbox"/> My grades this year are worse than last year	<input type="checkbox"/> I am disappointed with my grades <input type="checkbox"/> When I take a test, I can't think <input type="checkbox"/> I have a problem with completing/or don't complete my homework
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### Physical Concerns

<input type="checkbox"/> I have a lot of aches and pains <input type="checkbox"/> I have difficulty sleeping (i.e. nightmares or sleepwalking)	<input type="checkbox"/> I'm worried about my health or eating habits <input type="checkbox"/> I recently have had a big change in my weight or appetite <input type="checkbox"/> I need very little sleep
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### Substance Abuse

<input type="checkbox"/> I've got drunk on alcohol <input type="checkbox"/> I have close friends who get drunk or high	<input type="checkbox"/> I've tried marijuana or other drugs <input type="checkbox"/> Some people in my family drink or take drugs so much that it worries me
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What do you feel are your personal strengths? \_\_\_\_\_

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What are your favorite things to do? \_\_\_\_\_

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What four words best describe you? \_\_\_\_\_

Why? \_\_\_\_\_

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What do you hope to get out of treatment at ACG? \_\_\_\_\_

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What do you believe you need help with at this time in your life? \_\_\_\_\_

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What do you want to be when you grow up? \_\_\_\_\_

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Where do you see yourself in five years? \_\_\_\_\_

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Date: \_\_\_\_\_

## Parent Form for Adolescent

### Personal Information

Name: _____	Date of Birth: _____
Address: _____	City, State, Zip: _____
Form Completed By: _____	Relationship to Client: _____

### Contact numbers therapist can call:

Cell: _____	May we leave a message: _____
Home: _____	May we leave a message: _____
Other: _____	May we leave a message: _____

In case of emergency who should be contacted: \_\_\_\_\_

Primary #: \_\_\_\_\_ Secondary #: \_\_\_\_\_

Parents Marital Status:  Single  Married  Divorced  Widowed  Partner

If divorced, what are the custody agreements? \_\_\_\_\_

What is your reason for seeking in-home therapeutic behavioral care for your child at this time? \_\_\_\_\_

### Your Child's Developmental History

Is your child adopted?  Yes  No If yes, at what age? \_\_\_\_\_

Does your child know?  Yes  No Was this a cause of any major outburst?  Yes  No

What is your child(s) diagnose(s'): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

When was your child first diagnosed? \_\_\_\_\_



Are there any concerns with your child's motor development?  Yes  No

If yes, please explain: \_\_\_\_\_

Are there any concerns with your child's language development?  Yes  No

## **Educational History**

Where does your child attend school? \_\_\_\_\_

Highest (or current) Grade Level Achieved: \_\_\_\_\_

What have been your child's usual report card grades? \_\_\_\_\_

Any recent changes in grades?  Yes  No

If yes, please explain: \_\_\_\_\_

Has your child experienced any of the following in school?

Learning Problems  Discipline Problems  Social Problems  Emotional Problems

What is your child's learning style (visual, auditory, tactile, etc.)? \_\_\_\_\_

Does your child have an IEP? Yes  No

If yes, what is being addressed?

  
\_\_\_\_\_

Has there been any academic or psychological testing done at school or elsewhere? Yes  No

If yes: when and where? \_\_\_\_\_

Results: \_\_\_\_\_

  
\_\_\_\_\_

## **Spirituality**

Does your family have any past or current spiritual/religious beliefs, practices, or affiliations?

  
\_\_\_\_\_

Is your child involved with any religious activities? \_\_\_\_\_

  
\_\_\_\_\_

## **Physical Health/Concerns**

Describe any major health problems/surgeries/hospitalizations for any physical or emotional problem that your child has had or is currently being treated:

  
\_\_\_\_\_



What medication is your child currently taking (prescription/OTC/Supplements):

Name	Dose/Frequency	Purpose

*If more space is needed, please attach separate sheet.*

Do you have any nutritional concerns with your child?

Yes

No

If yes, please explain: \_\_\_\_\_

#### PHYSICIAN INFORMATION

Name of Physician(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Physician(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Psychiatrist(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Counselor(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_



## Emotional Concerns

Recent/Present Emotional Concerns (please check all of the symptoms below that apply to your child):

<input type="checkbox"/> Loss of Interest	<input type="checkbox"/> Difficulty Remembering	<input type="checkbox"/> Avoid Going Places
<input type="checkbox"/> Guilt	<input type="checkbox"/> Confusion	<input type="checkbox"/> Avoid Being With Others
<input type="checkbox"/> Concentration Difficulty	<input type="checkbox"/> Difficulty Making Decisions	<input type="checkbox"/> Checking Things Repeatedly
<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Pornography	<input type="checkbox"/> Intense Fear
<input type="checkbox"/> Thoughts of Self-Harm	<input type="checkbox"/> Taking Risks	<input type="checkbox"/> Concerns with alcohol
<input type="checkbox"/> Thoughts of Harming Others	<input type="checkbox"/> Racing Thoughts	<input type="checkbox"/> Concerns with Drug Use
<input type="checkbox"/> Depression	<input type="checkbox"/> Hearing Voices	<input type="checkbox"/> Excessive Technology Use
<input type="checkbox"/> Feelings of Hopelessness	<input type="checkbox"/> Seeing Things	<input type="checkbox"/> Work Problems
<input type="checkbox"/> Episodes of Crying	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Financial Problems
<input type="checkbox"/> Moody	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Learning Problems
<input type="checkbox"/> Feeling Empty Inside	<input type="checkbox"/> Anger	<input type="checkbox"/> Relationship Problems
<input type="checkbox"/> Afraid of Rejection	<input type="checkbox"/> Worry	<input type="checkbox"/> Easily Irritated
<input type="checkbox"/> Sensory Concerns	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

Are there any other concerns (not listed above) that you would like to discuss? \_\_\_\_\_

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Does your child have any psychiatric problems?  Yes  No

If so, please explain: \_\_\_\_\_

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Have your child's biological relatives had any psychiatric problems?  Yes  No

Has your child had a past history with trauma, abuse, or neglect?  Yes  No

If yes, please explain: \_\_\_\_\_

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Has your child had any major losses in his/her life?  Yes  No



What are your child's personal strengths and/or hobbies? \_\_\_\_\_

Has your child previously attended counseling?  Yes  No

What did you like about the program? \_\_\_\_\_

What did you dislike about the program? \_\_\_\_\_

Whom can your child rely on for support/resources? \_\_\_\_\_



## Consent & Agreement for Treatment – Minor

Client (Minor) Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I give Arizona Children's Group, and its affiliates, authorization to provide counseling and treatment services to my child, \_\_\_\_\_. I acknowledge that I authorize Arizona Children's Group to provide counseling and mental health services to my child in internal and external treatment facilities.

**If I participate in session with my child's therapist, I am required to review and sign the Consent & Agreement for Treatment for Adult Form.**

I, (Parent/Guardian) \_\_\_\_\_ do hereby authorize Arizona Children's Group to provide counseling/treatment services for my child, \_\_\_\_\_, as described in the Adult Consent Form. I give this consent as the client's custodial parent or legal representative.

**I understand that even if I do not participate in treatment, the therapist is able to share with me the following information without authorization from the client:**

- Current mental condition/status
- Diagnosis (dx)
- Treatment Needs/Recommendations
- Times and dates of service
- Billing / Insurance / Payment Information

I understand that I can revoke this consent at any time by sending written notice to  
[fip@arizonachildrensgroup.com](mailto:fip@arizonachildrensgroup.com).

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Printed Name of Parent/Legal Guardian

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Parent/Guardian Date of Birth

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Signature of Parent/Legal Guardian

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Date

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Signature of Arizona Children's Group Rep.

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Date



## Consent & Agreement for Treatment – Parent/Legal Guardian

CONSENT TO COLLECT, CREATE, USE, MAINTAIN AND DISCLOSE YOUR HEALTH INFORMATION  
(A separate form must be complete for each adult participating in treatment)

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. This information may include your health records, health history, symptoms, examination and test results, diagnosis, treatment plans, and billing and health insurance information. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment, or for other business (such as supervision) or required government functions (such as reporting abuse).

**The Arizona Children's Group Privacy Practice Notice explains in more detail your rights and how we can use and share your information. The ACG Privacy Policy is available online at [www.arizonachildrensgroup.com](http://www.arizonachildrensgroup.com) and available in each of the Arizona Children's Group facilities.**

### **Informed Consent**

Informed Consent is an interactive process between client and therapist involving your right to have the following information explained to you:

- Your condition or diagnosis
- The nature and purpose of treatment
- The likelihood of success
- The risks and potential consequences of treatment, including refusing treatment and the consequences of doing so
- The right to include or exclude your family or significant other/s in treatment, to the extent permitted by the law

### **By Signing This Form, I Am Indicating**

- I have read, understand and agree to the terms of the Consent & Agreement for Treatment as outlined above, except as otherwise noted in writing.
- I have been given the opportunity to review and have access to a copy of the ACG Privacy Practice Notice. ACG reserves the right to change its notice and practices at any time, if it sends a copy of the revised notice to the address that I have provided.
- As a consenting adult, I agree to permit the staff at ACG to provide me with treatment services.
- I understand that I have the right to request restrictions on the use or disclosure of my information. I understand that ACG is not required to agree to those restrictions, but if it does, it must honor the restriction unless I revoke the request or it notifies me that it is no longer going to honor the request. ACG has a form available for me to complete if I wish to request a restriction.
- I understand that I have the right to discontinue treatment at any time.
- **If I do not sign this consent form, ACG will not be able to treat me.**

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date of Signature: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_



## Consent & Agreement for Treatment – Parent/Legal Guardian for Minor Child

CONSENT TO COLLECT, CREATE, USE, MAINTAIN AND DISCLOSE YOUR HEALTH INFORMATION  
(A separate form must be complete for each child participating in treatment)

When we examine, diagnose, treat, or refer your child we will be collecting what the law calls Protected Health Information (PHI). This information may include your child(s) health records, health history, symptoms, examination and test results, diagnosis, treatment plans, and billing and health insurance information. We need to use this information to decide on what treatment is best for your child and to provide treatment. We may also share this information with others who provide treatment to your child or need it to arrange payment for their treatment, or for other business (such as supervision) or required government functions (such as reporting abuse).

**The Arizona Children's Group Privacy Practice Notice explains in more detail your rights and how we can use and share your child(s) information. The ACG Privacy Policy is available online at [www.arizonachildrensgroup.com](http://www.arizonachildrensgroup.com) and available in each of the Arizona Children's Group facilities.**

### Informed Consent

Informed Consent is an interactive process between client and therapist involving your right to have the following information explained to you:

- Your child's condition or diagnosis
- The nature and purpose of treatment
- The likelihood of success
- The risks and potential consequences of treatment, including refusing treatment and the consequences of doing so
- The right to include or exclude your family or significant other/s in treatment, to the extent permitted by the law

### By Signing This Form, I Am Indicating

- I have read, understand and agree to the terms of the Consent & Agreement for Treatment as outlined above, except as otherwise noted in writing.
- I have been given the opportunity to review and have access to a copy of the ACG Privacy Practice Notice. ACG reserves the right to change its notice and practices at any time, if it sends a copy of the revised notice to the address that I have provided.
- As a consenting adult, I agree to permit the staff at ACG to provide my child with internal and external treatment services.
- I understand that I have the right to request restrictions on the use or disclosure of my information. I understand that ACG is not required to agree to those restrictions, but if it does, it must honor the restriction unless I revoke the request or it notifies me that it is no longer going to honor the request. ACG has a form available for me to complete if I wish to request a restriction.
- I understand that I have the right to discontinue treatment for my child at any time.
- **If I do not sign this consent form, ACG will not be able to treat my child.**

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date of Signature: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_



## Authorization for Use or Disclosure of Protected Health Information

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize Arizona Children's Group to use or disclose my protected health information as described below:

**Specific information I authorize to be used or disclosed is:** Behavioral Health, Mental Health, Treatment Planning, Overall Health/Wellness, and Residential Living Requirements/Assessments.

**Organization/s or Person/s Arizona Children's Group is authorized to release my information to:** Beyond Counseling, LLC, Southwest Behavioral Health Services, Nurse Tee Global, and International Rescue Committee.

**Purpose/s of the use or disclosure:**

At the Request of the Individual  
 other: \_\_\_\_\_

**Consequences of my refusal to sign this authorization:**

Arizona Children's Group will not be able to communicate with the Organization/s person/s listed above  
 other: \_\_\_\_\_

I understand the following:

- Any information used or disclosed because I have signed his authorization may no longer be protected by privacy laws and may be subject to re-disclosure by the person or organization who is receiving it.
- I have the right to revoke this authorization at any time by doing so in writing and presenting my written revocation to Arizona Children's Group.
- Any request to revoke this authorization will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Any request to revoke this authorization will not apply to the extent Arizona Children's Group has taken action in reliance upon my authorization.
- I may refuse to sign this authorization and Arizona Children's Group will not condition treatment based upon my providing a signature on this authorization unless it is for research related treatment or provision of care for the sole purpose of creating information for a third party.
- I may inspect or copy any information to be used or disclosed based on this authorization.

Client's or Legal Representative's Initials \_\_\_\_\_

This authorization expires on January 30<sup>th</sup>, 2021, or upon the event of written revocation.

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Signature of Parent or Legal Guardian

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Date

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Legal Representatives Printed Name

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Relationship to Client

Important Notice: Any information protected by Federal Regulations governing substance abuse treatment or the Arizona Mental Health and Developmental Disabilities Confidentiality Act is prohibited from further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.



## Consent & Agreement for Education Enrollment

CONSENT TO USE, MAINTAIN AND DISCLOSE YOUR CHILDS PERSONAL INFORMATION  
(A separate form must be complete for each child participating in treatment)

When we enroll your child into the Arizona Children's Group Residential Program, it is important that we comply with State Law and immediately enroll your child in school. In this process, we will act as the legal guardian of your child for the sole purpose in registration and oversight of your child's education. . We may also share this information with others who provide care to your child or need it to arrange transportation for their schooling, or for other educational (such as supervision) or required functions (such as reporting abuse).

**The Arizona Children's Group Privacy Practice Notice explains in more detail your rights and how we can use and share your child(s) information. The ACG Privacy Policy is available online at [www.arizonachildrensgroup.com](http://www.arizonachildrensgroup.com) and available in each of the Arizona Children's Group facilities.**

### Informed Consent

Informed Consent is an interactive process between legal guardian and facility involving your right to have the following information explained to you:

- Your child's school name and class schedule
- Your child's teachers name and contact information
- Your child's semester and official transcript grades
- Updates in your child's education or peer atmosphere
- The right to be listed as the Emergency Contact on your child's contact card and schooling information

### By Signing This Form, I Am Indicating

- I have read, understand and agree to the terms of the Consent & Agreement for Education Enrollment as outlined above, except as otherwise noted in writing.
- I have been given the opportunity to review and have access to a copy of the ACG Privacy Practice Notice. ACG reserves the right to change its notice and practices at any time, if it sends a copy of the revised notice to the address that I have provided.
- As a consenting adult, I agree to permit the staff at ACG to enroll my child in school and communicate directly with the school of choice on my behalf.
- I understand that I have the right to request restrictions on the use or disclosure of my child's information. I understand that ACG is not required to agree to those restrictions, but if it does, it must honor the restriction unless I revoke the request or it notifies me that it is no longer going to honor the request. ACG has a form available for me to complete if I wish to request a restriction.
- I understand that I have the right to discontinue treatment for my child at any time.
- **If I do not sign this consent form, ACG will not be able to enroll my child in school.**

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date of Signature: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_