Please return these forms to:
9734 Jug St. NW, Pataskala, OH 43062
Or Fax: 740-924-2002

If you have questions, please contact us at:
Phone: 740-924-7543
Or email: info@pbjconnections.org

Client Information

Client Legal Name: ____ Preferred Name: ______________________

Date of Birth: __________________ Age: _____ Administrative Sex: Male Female

Gender Identity (optional): ________________________ Sexual Orientation (optional): ____________________

Marital Status: ___________________ Race:_________________ Language(s) Spoken: _____________________

Address: ____

Phone: (Cell)_______________________(Home)________________________(Other)_______________________

Email: ____

Appointment Reminder Preference: Text____ Call____ Email (preferred) ____

If Client is a Minor:
Parent/Legal Custodian: ____

Address (if differs from above): ____

If there is a parenting or custody agreement, who is named in the agreement? ___________________________
(Please bring copies of these documents to your intake.)
Are you currently involved in a court case relating to custody, divorce, or child dependency action? yes no

Additional Information:
I am seeking (circle all applicable): **Equine (horse) Assisted Psychotherapy**

Traditional Office Therapy or **Telehealth (Video Calls)**

What is the main reason for seeking our services for your child/self/family?

Additional Information:
Employer/School: ____

How did you hear about the program? ____

Does the client or family member who may be participating require any assistance? If so, what type of assistance is needed? (i.e. interpreter, physical assistance) ____

PRIMARY INSURANCE INFORMATION: <u>Must be completed to bill your Insurance</u>

Please bring your insurance card to the first appointment

Insurance Name: ____ Plan Name: ___________________________

Deductible: ________________Visit co-pay:________________

Subscriber/ Member ID: _____________________________________Group No: ___________________________

Clients Relationship to Primary Insured: (**required circle one**) Self Spouse Child Other

If client is not the policy holder, please complete the section below:
Policy Holder Full Legal Name: ____

Date of Birth: ________________ Marital Status: ___________________ Phone: ______________________

Policy Holder Street Address: ____

City: ______________________ State: ________ Zip Code: ______________

Email: ____

Secondary Insurance

Policy Holder Name: _____________________________________ Date of Birth: _______________

Relationship to Client: ______________________ Insurance Name:_____________________________________

Subscriber/ Member ID: ____Group No: _____________________

GreenPointMed will bill your insurer directly for all services utilizing the HIPAA compliant system, *Therapy Notes*. Your signature expresses your agreement that the dates of service, services rendered, and diagnosis will be provided to GreenPointMed for billing purposes only. The client's or responsible person's signature below authorizes release of any medical information requested by the insurer in order to process insurance claims and authorizes payment of medical benefits to be made directly to the supplier of services.

Signature____**Date**________________

Authorization for Emergency Medical Treatment Form

Name: ____ DOB: ___________________

Primary Care Provider Name and Number: ____

Allergies to medications: ____

Current medications: ____

In the event of an emergency, contact:

Name: _________________________ Relation: ________________ Phone: __________________

Name: _________________________ Relation: ________________ Phone: __________________

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize PBJ Connections, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This will only be invoked if the person(s) above is unable to be reached.

Date: ______________ Consent Signature: ____

Participant or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. I understand that in the case of an emergency, a critical response team will be contacted via 911, and they will be provided with this form. In the event emergency treatment/aid is required, I wish the following procedures to take place:

____

____

____

Date: ______________ Consent Signature: ____

Participant or Legal Guardian

Consent for Release of Confidential Information

Client's Name: ____________________________________ Date of Birth: ___________

Legal Guardian (if applicable): ____________________________________

By signing below, I agree to give PBJ Connections permission to exchange/give/receive/share/re-disclose information regarding treatment with the following:

Primary Care Provider Name/Office: ____

Phone Number of Primary Care Provider: ____

Information exchanged may include treatment plans/progress, psychiatric/psychosocial assessments, diagnosis, and any other information related to the treatment of said client. Information will be utilized for mental health/behavioral health treatment of the client, as well as proving the Primary Care Provider information that may be pertinent to the client's overall health. **This document is valid for 12 months** unless revoked by the client or legal guardian.

Pursuant to Federal Regulations, this information will not be forwarded to any other provider or agent.

____

Client Date

____

Parent or Legal Guardian (if applicable) Date

On Behalf of PBJ Connections, Inc.:

____

Clinician Date

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