# Patient Record Update

Patient Information

Name:____________________ SSN:____________________

Add1:____________________ DOB:____________________

Add2:____________________ Home Phone:____________________

City:____________________ Work Phone:____________________

State:__________ Zip:__________ Cell Phone:____________________

Guarantor Information - if different from self

Name:____________________ SSN:____________________

Add1:____________________ DOB:____________________

Add2:____________________ Home Phone:____________________

City:____________________ Work Phone:____________________

State:__________ Zip:__________ Relationship:____________________

Employer Information

Name:____________________ Occupation:____________________

Add1:____________________

City:____________________

State:__________ Zip:__________

Insurance Information: Please provide copies of cards to the receptionist

Primary Insurance Information

Plan Name:____________________ Policy#:____________________

Cardholder:____________________ DOB:____________________

Relationship to patient: (circle one) __Self__Spouse__Parent__Other____ SSN:____________________

Have you contacted your insurance regarding your Mental Health benefits?____________________

If yes, what are they?____________________

Insurance Information: Please provide copies of cards to the receptionist

Secondary Insurance Information

Plan Name:____________________ Policy#:____________________

Cardholder:____________________ DOB:____________________

Relationship to patient: (circle one) __Self__Spouse__Parent__Other____ SSN:____________________

Have you contacted your insurance regarding your Mental Health benefits?____________________

If yes, what are they?____________________

Pharmacy Name:____________________ Pharmacy Phone Number:____________________

Address:____________________

City:__________ State:__________ Zip:__________

Signature: Date:

## FINANCIAL POLICY

Thank you for choosing our doctors and therapists to meet your needs. The following is a statement of our Financial Policy, which we ask you to read and sign prior to treatment.

Psychiatric and psychological services have already been handled differently by insurance companies than medical/surgical services; therefore we ask you to become as knowledgeable as possible about your particular insurance plan.

YOUR PORTION OF PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, DISCOVER, AND MASTERCARD.

## MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to________________ ____________________________________ for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

## INSURANCE

Your insurance policy is a contract between you and your insurance company. If you have given us all the required information, we can submit the mental health services to the insurance companies with which we participate. We must have current policy, group, ID, and claim numbers. We will make a copy of your insurance card. Please be aware that some services may be "non-covered" services according to your policy. You are still responsible for payment of these services.

Many of us are members of "provider panels" of certain companies. If this is true for your insurance, then part of the payment will come directly to us from the company. You will need to pay a "co-payment" at each visit, the amount of which is determined by *your insurance company* (not be us). You will need to call your insurance carrier to learn what you co-payment will be. You may also need to be in touch with them from time to time in order to make sure that your claims are being paid and that your coverage is still authorized for our services.

If you are covered by an insurance carrier that requires precertification, it is your responsibility to call the company for authorization prior to your first appointment. If you do not have authorization, you will be billed for the services.

We accept the approved amount for some major insurance companies and some HMO and PPO programs, however please have the employer name, claim number, and address of where the claim should be sent. We require written preauthorization from the insurance carrier for all auto insurance and Workers' Compensation cases.

Please note we do not participate in Medical Assistance.

## COMMERCIAL INSURANCE

I hereby authorize the release of information necessary to file a claim with my insurance company and *assign benefits otherwise payable to me to the physician indicated on the claim.*

I understand that I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

Signature______________________________________ Date______________________

## MINOR PATIENTS (UNDER 18 YEARS OF AGE)

The parent/guardian/adult accompanying a minor child is responsible for full payment. If both parents have insurance, the parent with the first birthday in the year is most often the primary insurer. Please check your insurance policy to determine which company is primary before your appointment. In divorce cases, we will bill our participating insurances, but the parent who brings the child in for services is ultimately the responsibility party.

## FORENSIC EVALUATIONS

Forensic Evaluations are usually not covered by insurance and are paid in full prior to the evaluation unless alternative arrangements are made.

## BILLING

A Billing statement covering your services will be mailed to you each month. We expect payment to be made on a timely basis. A past due account will be turned over to our collection agency if no payment has been made.

I have read, understand, and agree to this Financial Policy.

______________________________________ ______________________

Signature of Patient of Responsible Party Date

Form 28 Couple's Information Form

1. Name: ______________________ 2. Age: ________ 3. Date: ______________
4. Address: ______________ City: __________ State: ________ Zip: ______________
5. Briefly, what is your main purpose in coming to couple's counseling? ____________________
______________________________________________________________

**Instructions:** To assist us in helping you, please fill out this form as fully and openly as possible. Your answers will help plan a course of couple's therapy that is most suitable for you and your partner. Do not exchange this information with your partner at this time.

Several of your answers on this form may be shared later with your partner during joint therapy sessions if you give us permission to share this information. For this reason you are advised to respond honestly and carefully to each item. If certain questions do not apply to you or you do not want to share this information, please leave them blank.

6. Have you been married before? ___ Yes ___ No
   If Yes, how many previous marriages have you had? 1 2 3 4 5+
7. How long have you and your partner been in this relationship? __
8. Are you and your partner presently living together? ___ Yes ___ No
9. Are you and your partner engaged to be married? ___ Yes When? ______________ ______ No
10. Fill out the following information for each child of whom the natural parent is both you and your partner, children from previous relationships, and adopted children.
   ___ Neither of us has children (go to next page) ___ One or each of us has children (continue)
   *"Whose child?" answering options: B = Both of ours, natural child
   BA = Both of ours, adopted (or taken on)
   M = My natural child
   MA = My child, adopted (or taken on)
   P = Partner's natural child
   PA = Partner's child, adopted (or taken on)

| | Child's name | Age | Sex | *Whose child? | Lives with whom |
|---|---|---|---|---|---|
| (1) | ______________________ | ______ | F M | ________ | ___ Yes ___ No |
| (2) | ______________________ | ______ | F M | ________ | ___ Yes ___ No |
| (3) | ______________________ | ______ | F M | ________ | ___ Yes ___ No |
| (4) | ______________________ | ______ | F M | ________ | ___ Yes ___ No |
| (5) | ______________________ | ______ | F M | ________ | ___ Yes ___ No |
| (6) | ______________________ | ______ | F M | ________ | ___ Yes ___ No |
| (7) | ______________________ | ______ | F M | ________ | ___ Yes ___ No |
| (8) | ______________________ | ______ | F M | ________ | ___ Yes ___ No |

11. List five qualities that initially attracted you to your partner:

| | Does your partner still possess this trait? |
|---|---|
| (1) ________ | ___ Yes ___ No |
| (2) ________ | ___ Yes ___ No |
| (3) ________ | ___ Yes ___ No |
| (4) ________ | ___ Yes ___ No |
| (5) ________ | ___ Yes ___ No |

12. List four negative concerns that you initially had in the relationship:

| | Does your partner still possess this trait? |
|---|---|
| (1) ________ | ___ Yes ___ No |
| (2) ________ | ___ Yes ___ No |
| (3) ________ | ___ Yes ___ No |
| (4) ________ | ___ Yes ___ No |

13. List five present positive attributes of your partner:

| | Do you often praise your partner for this trait? |
|---|---|
| (1) ________ | ___ Yes ___ No |
| (2) ________ | ___ Yes ___ No |
| (3) ________ | ___ Yes ___ No |
| (4) ________ | ___ Yes ___ No |
| (5) ________ | ___ Yes ___ No |

14. List five present negative attributes of your partner:

| | Do you nag your partner about this trait? |
|---|---|
| (1) ________ | ___ Yes ___ No |
| (2) ________ | ___ Yes ___ No |
| (3) ________ | ___ Yes ___ No |
| (4) ________ | ___ Yes ___ No |
| (5) ________ | ___ Yes ___ No |

15. List five things you do (or could do) to make the marriage more fulfilling for your partner:

| | Do you often implement this behavior? |
|---|---|
| (1) ________ | ___ Yes ___ No |
| (2) ________ | ___ Yes ___ No |
| (3) ________ | ___ Yes ___ No |
| (4) ________ | ___ Yes ___ No |
| (5) ________ | ___ Yes ___ No |

16. List five things that your partner does (or could do) to make the marriage more fulfilling for you:

| | Does your partner often implement this behavior? |
|---|---|
| (1) ______________________ | ___ Yes ___ No |
| (2) ______________________ | ___ Yes ___ No |
| (3) ______________________ | ___ Yes ___ No |
| (4) ______________________ | ___ Yes ___ No |
| (5) ______________________ | ___ Yes ___ No |

17. List five expectations or dreams you had about relationships before you met your partner:

| | Has this been fulfilled? |
|---|---|
| (1) ______________________ | ___ Yes ___ No |
| (2) ______________________ | ___ Yes ___ No |
| (3) ______________________ | ___ Yes ___ No |
| (4) ______________________ | ___ Yes ___ No |
| (5) ______________________ | ___ Yes ___ No |

18. On a scale of 1 to 5, rate the following items as they pertain to:
(1) The present state of the relationship
(2) Your need or desire for it
(3) Your partner's need or desire for it

**Circle the Appropriate Response for Each (If not applicable, leave blank.)**

| | Present state of the relationship<br>Poor Great | Your need or desire<br>Low High | Partner need or desire<br>Low High |
|---|---|---|---|
| (1) Affection | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (2) Childrearing rules | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (3) Commitment together | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (4) Communication | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (5) Emotional closeness | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (6) Financial security | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (7) Honesty | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (8) Housework sharing | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (9) Love | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (10) Physical attraction | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (11) Religious commitment | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (12) Respect | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (13) Sexual fulfillment | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (14) Social life together | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (15) Time together | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (16) Trust | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| Other (specify) | | | |
| (17) ____________ | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (18) ____________ | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (19) ____________ | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |
| (20) ____________ | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |

19. For couples living together. Which partner spends more time conducting the following activities?

Circle the Appropriate Response for Each (If not applicable, leave blank.)

(M = Me P = Partner E = Equal time)

| | | Is this equitable (fair)? | Comments |
|---|---|---|---|
| (1) Auto repairs | M P E | ___ Yes ___ No | ___________ |
| (2) Child care | M P E | ___ Yes ___ No | ___________ |
| (3) Child discipline | M P E | ___ Yes ___ No | ___________ |
| (4) Cleaning bathrooms | M P E | ___ Yes ___ No | ___________ |
| (5) Cooking | M P E | ___ Yes ___ No | ___________ |
| (6) Employment | M P E | ___ Yes ___ No | ___________ |
| (7) Grocery shopping | M P E | ___ Yes ___ No | ___________ |
| (8) House cleaning | M P E | ___ Yes ___ No | ___________ |
| (9) Inside repairs | M P E | ___ Yes ___ No | ___________ |
| (10) Laundry | M P E | ___ Yes ___ No | ___________ |
| (11) Making bed | M P E | ___ Yes ___ No | ___________ |
| (12) Outside repairs | M P E | ___ Yes ___ No | ___________ |
| (13) Recreational events | M P E | ___ Yes ___ No | ___________ |
| (14) Social activities | M P E | ___ Yes ___ No | ___________ |
| (15) Sweeping kitchen | M P E | ___ Yes ___ No | ___________ |
| (16) Taking out garbage | M P E | ___ Yes ___ No | ___________ |
| (17) Washing dishes | M P E | ___ Yes ___ No | ___________ |
| (18) Yard work | M P E | ___ Yes ___ No | ___________ |
| (19) Other: ________ | M P E | ___ Yes ___ No | ___________ |
| (20) Other: ________ | M P E | ___ Yes ___ No | ___________ |

20. If some of the following behaviors take place only during MILD arguments, circle an "M" in the appropriate blanks. If they take place only during SEVERE arguments, circle an "S." If they take place during ALL arguments, circle an "A." Fill this out for you and your impression of your partner. If certain behaviors do not take place, leave them blank.

Circle the Appropriate Response for Each

(M = Mild arguments only S = Severe arguments only A = All arguments)

| Behavior | By me | By partner | Should this change? |
|---|---|---|---|
| (1) Apologize | M S A | M S A | ___ Yes ___ No |
| (2) Become silent | M S A | M S A | ___ Yes ___ No |
| (3) Bring up the past | M S A | M S A | ___ Yes ___ No |
| (4) Criticize | M S A | M S A | ___ Yes ___ No |

| | | | |
|---|---|---|---|
| (5) Cruel accusations | M S A | M S A | ___Yes ___No |
| (6) Cry | M S A | M S A | ___Yes ___No |
| (7) Destroy property | M S A | M S A | ___Yes ___No |
| (8) Leave the house | M S A | M S A | ___Yes ___No |
| (9) Make peace | M S A | M S A | ___Yes ___No |
| (10) Moodiness | M S A | M S A | ___Yes ___No |
| (11) Not listen | M S A | M S A | ___Yes ___No |
| (12) Physical abuse | M S A | M S A | ___Yes ___No |
| (13) Physical threats | M S A | M S A | ___Yes ___No |
| (14) Sarcasm | M S A | M S A | ___Yes ___No |
| (15) Scream | M S A | M S A | ___Yes ___No |
| (16) Slam doors | M S A | M S A | ___Yes ___No |
| (17) Speak irrationally | M S A | M S A | ___Yes ___No |
| (18) Speak rationally | M S A | M S A | ___Yes ___No |
| (19) Sulk | M S A | M S A | ___Yes ___No |
| (20) Swear | M S A | M S A | ___Yes ___No |
| (21) Threaten breaking up | M S A | M S A | ___Yes ___No |
| (22) Threaten to take kids | M S A | M S A | ___Yes ___No |
| (23) Throw things | M S A | M S A | ___Yes ___No |
| (24) Verbal abuse | M S A | M S A | ___Yes ___No |
| (25) Yell | M S A | M S A | ___Yes ___No |
| (26) ________________ | M S A | M S A | ___Yes ___No |
| (27) ________________ | M S A | M S A | ___Yes ___No |
| (28) ________________ | M S A | M S A | ___Yes ___No |

21. How often do you have: Mild arguments? ______________________________

Severe arguments? ______________________________

22. When a MILD argument is over how do you usually feel?

**Check Appropriate Responses**

| | |
|---|---|
| ___ Angry | ___ Lonely |
| ___ Anxious | ___ Nauseous |
| ___ Childish | ___ Numb |
| ___ Defeated | ___ Regretful |
| ___ Depressed | ___ Relieved |
| ___ Guilty | ___ Stupid |
| ___ Happy | ___ Victimized |
| ___ Hopeless | ___ Worthless |
| ___ Irritable | |

23. When a SEVERE argument is over how do you usually feel?

**Check Appropriate Responses**

| | |
|---|---|
| ___ Angry | ___ Lonely |
| ___ Anxious | ___ Nauseous |
| ___ Childish | ___ Numb |
| ___ Defeated | ___ Regretful |
| ___ Depressed | ___ Relieved |
| ___ Guilty | ___ Stupid |
| ___ Happy | ___ Victimized |
| ___ Hopeless | ___ Worthless |
| ___ Irritable | |

24. Which of the following issues or behaviors of you and/or your partner may be attributable to your relationship or personal conflicts? If an item does not apply, leave it blank.

Circle the Appropriate Responses

(M = My behavior  P = Partner's behavior  B = Both)

| | | | | | |
|---|---|---|---|---|---|
| Alcohol consumption | M P B | Perfectionist | M P B |
| Childishness | M P B | Possessive | M P B |
| Controlling | M P B | Spends too much | M P B |
| Defensiveness | M P B | Steals | M P B |
| Degrading | M P B | Stubbornness | M P B |
| Demanding | M P B | Uncaring | M P B |
| Drugs | M P B | Unstable | M P B |
| Flirts with others | M P B | Violent | M P B |
| Gambling | M P B | Withdrawn | M P B |
| Irresponsibility | M P B | Works too much | M P B |
| Lies | M P B | Other (specify) | |
| Past marriage(s)/relationship(s) | M P B | ______________ | M P B |
| Other's advice | M P B | ______________ | M P B |
| Outside interests | M P B | ______________ | M P B |
| Past failures | M P B | ______________ | M P B |

25. In the remaining space, please provide additional information that would be helpful:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

I, ______________________________, hereby give my permission for this clinic to share the information that I provide on this form with ______________________________ (partner) when it is deemed appropriate by an agreement between me, my partner, and our therapist. This sharing of information may take place only during a joint counseling session (both partners present).

Client's signature: ________________________________________ Date:___/___/___

PLEASE RETURN THIS AND OTHER ASSESSMENT MATERIALS TO THIS OFFICE AT LEAST TWO DAYS BEFORE YOUR NEXT APPOINTMENT.

# Notice of Privacy Practices – Short Version

## THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. This pamphlet is a shorter version of the full, legally required NPP which you may request for more information. However, we can't cover all possible situations so please talk to our Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services or for some other business activities which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If we obtain information that requires us by law to report suspected child abuse.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

**Your rights regarding your health information**

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can always get a copy of the NPP from the office receptionist or Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer: Paul E. Delfin, Ph.D.,
DGR Behavioral Health, LLC
2201 Ridgewood Road, Suite 400
Wyomissing, PA 19610

Phone: 610-378-9601

The effective date of this notice is December 1, 2015.

DGR Behavioral Health, LLC
2201 Ridgewood Road, Suite 400
Wyomissing, PA 19610
Telephone (610) 378-9601
Fax (610) 378-9061

## Acknowledgment of Receipt of Notice of Privacy Practices

**Patient Name:**______________________________________________

**Birth Date:** ______________________________________________

**Maiden or other name** (if applicable):

______________________________________________

I acknowledge that I have received a copy of the Notice of Privacy Practices of DGR Behavioral Health, LLC, effective December 31, 2014.

**Signature** (patient or authorized representative):

______________________________________________

**Date:**

______________________________________________

**Relationship/authority**
(if signed by authorized representative):

______________________________________________

# DGR Policies

**DGR BEHAVIORAL HEALTH ELECTRONIC COMMUNICATIONS POLICY**

E-mail is only for scheduling or for a clinical reason that we can discuss ahead of time.

E-mail is not a substitute for discussions that should take place face-to-face.

E-mails should never be used for emergencies.

Do not e-mail your provider if you expect a quick response, as we only check e-mail occasionally.

We do not follow patients' blogs, follow patients on Twitter, Google them, friend them, or communicate by texting.

Cell phones should be off (or in silent mode) during sessions. Secret recording of sessions is not permitted.

To protect your privacy and respect that of others, please do not have cell phone conversations in the waiting room.

**Please review and keep for your records.**

**FRAGRANCE POLICY**

This is a fragrances-free workplace. Thank you for not wearing any of the following during your visit: cologne, after shave lotion, perfume, perfumed hand lotion, fragranced hair products, and/or similar products. Our chemically-sensitive co-workers and clients thank you.

## CANCELLATION POLICY

We consider an appointment to be a commitment and an agreement. When an appointment is scheduled, the time is set-aside for you and no one else. Consequently, unlike other doctors' offices, we do not double or triple book patients. However, in order to do this, we must charge a fee for all appointments not cancelled within 24 hours of the appointment. If your appointment falls on a Monday, you may leave a message with the answering service over the preceding weekend.

| | |
|---|---|
| Cancelled Appointments: | No charge will be made for any appointment cancelled with at least 24 hours advance notice. |
| Missed Appointments: | An appointment cancelled on less than a 24-hour notice, or an appointment missed without a notice of cancellation, will be billed a cancellation fee. This fee will not be charged to insurance, and is your responsibility to pay in full. |
| Exception: | Same-day cancellations because of serious medical/family emergencies or dangerous road conditions (snow and ice) will not be charged, as long as a telephone call is received in the office before the scheduled appointment time. |

We will try to give you a reminder call if you have requested one. However, you are responsible for the appointment whether or not you receive that call.

I am aware of the cancellation policy and agree to the terms.

______________________________ ______________________

Signature Date

______________________________

Parent Signature if appropriate