CLIENT INTAKE AGREEMENT

Child's Name: .....

Parent/Guardian: .....

Child's Information

Full Name:

Date of Birth: | Age:

Gender: | School:

Contact No.: | Email:

Address:

Primary Care Physician:

Parent/Guardian Information

Full Name:

Contact No.: | Email:

Relationship to the Child: | Living together? ☐ Yes ☐ No

Address:

Emergency Contact

Full Name:

Contact No.: | Home No.:

Relationship to the Child: | Living with the child? ☐ Yes ☐ No

Who referred you to our services?

Referrer's Name:

Relationship with the referrer?

- ☐ Family or Friends
- ☐ School
- ☐ Social Services
- ☐ Doctor
- ☐ Others: .....

Insurance Information

Insurance Provider:

Subscriber's Name:

Relationship to Subscriber:

Insurance Policy Number:

Insurance Group Number:

Treatment Consent

- I, the undersigned, hereby consent to treatment for my child through Uncharted Outreach.
- I understand that treatment will be based on a psychosocial rehabilitative approach aimed at improving my child's social and emotional functioning.
- I give my consent for Uncharted Outreach to share necessary treatment information with relevant entities such as Managed Care Organizations (MCOs) and the Texas Medicaid program.

Date signed:

Parent/Guardian Signature: