DONARSKI CENTER *for* MENTAL HEALTH COUNSELING

2025 INFORMATION UPDATE AND AUTHORIZATION (CHILD)

DEMOGRAPHIC INFORMATION

Child's Name: First _____ Middle _____ Last _____

Birthday: _____/_____/_____ Primary Phone: _____

Address: _____ City/State: _____ Zip Code: _____

Your Name: First _____ Last _____

Circle One: Parent Step Parent Guardian

Phone: Home: _____ Cell: _____ Work: _____

Address: _____ City/State: _____ Zip Code: _____

Email: _____

Do you have full legal custody of this child? YES NO If no, what is the custody arrangement? _____

I consent to my child/stepchild/ward participating in behavioral health care.

Signature: _____ Date: _____

OTHER ADULTS WHO CARE FOR THIS CHILD

Name: First _____ Last _____

Circle One: Parent Step Parent Guardian Cell Phone: _____

Name: First _____ Last _____

Circle One: Parent Step Parent Guardian Cell Phone: _____

Name: First _____ Last _____

Circle One: Parent Step Parent Guardian Phone: Cell: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

Please complete the back side of this form

PRIMARY INSURANCE (If we copied your insurance card(s), you may skip the Primary & Secondary Insurance Portion)

Insurance Provider: _____ ID# _____

Group/Plan: _____ Policy Holder's Name: _____

Birthdate: ____/____/_____ Social Sec: _____-_____-_____ Relationship to client: _____

Insured's address if different from child: _____

Address on back of card: _____

SECONDARY INSURANCE

Insurance Provider: _____ ID# _____

Group/Plan: _____ Policy Holder's Name: _____

Birthdate: ____/____/_____ Social Sec: _____-_____-_____ Relationship to client: _____

Insured's address if different from child: _____

Address on back of card: _____

I understand that I am responsible for this child's fees. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. I will honor contractual agreements made with managed health care companies which stipulate specific reimbursement restrictions.

I hereby consent to this child being treated by a specified provider. Although the chances for obtaining goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment for this child at any time. I understand that I am responsible, however, for any balance prior to a decision to end therapy.

I hereby authorize the release of necessary medical information for insurance reimbursement purposes. Furthermore, I authorize the payment of medical benefits to the Donarski Center for Mental Health Counseling, LLC/Edwin R. Vergara MA, LPC (provider services).

I have read the following documents: Informed Consent for Treatment, Health Insurance Portability and Accountability Act (HIPAA) Notification, and Payment and Insurance Agreement which are available at www.DonarskiCenter.com and upon request in the Donarski Center office. Signing this form indicates my agreement and consent with these notifications and authorizations as well as my agreement that Donarski Center may contact me with detailed information regarding appointments, treatment, and billing via methods I shared on this document or on intake forms.

Parent/Step Parent/Guardian:

Signature: _____

Date: _____