Rainbow Resiliency, LLC

CLIENT REGISTRATION

Name: _____ Today's Date: _____

Legal Name (if different): _____ Pronouns: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Date of Birth: _____ Gender: _____ Home Phone: _____ Cell: _____

Race/Ethnicity: _____ Current mental health diagnosis(es): _____

Client's Spouse(s)/Partner(s) (if applicable): _____

(If Client is a Student) Name of School: _____ Grade:_____

Primary Care: _____ Psychiatric Provider: _____ Nutritionist: _____

Current medications & dosages: _____

Person to contact in an emergency: _____ Phone: _____

Would you like to receive text reminders for your appointments the day before? (*please check one*) Y ____ N _____

If yes on what number? _____

TELEHEALTH AGREEMENT

I have agreed to participate in virtual sessions, or telehealth, for my mental health services. I am aware of the potential risks associated with telehealth. My provider uses a HIPAA-compliant version of Zoom. I understand that it is my responsibility to be somewhere that is private & confidential at the time of my session. I understand that if I ask my provider to use a different online meeting platform (ie. FaceTime) that the service will no longer be HIPAA-compliant and I am willingly risking my online privacy by choosing this method of service delivery. Additionally, I understand that my provider is available to email/text for logistical purposes; and my provider is available through Simple Practice secure messaging or phone/voicemail for clinical messaging. I understand that my provider is not available outside of their specified times of service.

Signature: _____ Date: _____

FOR TREATMENT OF A MINOR

As the parent or legal guardian of _____, I authorize the evaluation and treatment by providers at Rainbow Resiliency, LLC. As parent or legal guardian, I have the right to request information concerning the above minor's evaluation and treatment.

Signature: _____ Date: _____