TAHOE YOUTH & FAMILY SERVICES

A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

YOUTH 10-17

Dear Client,

Thank you for your interest in Tahoe Youth & Family Services. We hope that the following information will help you complete this intake packet.

Tahoe Youth & Family Services believes that the family plays a significant role in the success of every family member's development and experience with our agency. Below are some tips to help you with the intake packet as well as the counseling experience.

- If a minor is the primary client, the only paperwork that is NOT to be filled out by, or about, the minor is the questionnaire marked "Parent/Guardian Questionnaire" on the top right corner.
- Please be on time for your scheduled appointment. **We require a 24-hour notice of cancellation** so that we may plan accordingly. Tahoe Youth & Family Services' policy is to discharge clients after 2 cancellations without prior notice.
- **Please bring only those children being seen for your scheduled appointment**. You will find that our lobby is not conducive to waiting with young children for an hour.
- Please be aware that TYFS accepts credit/debit cards and cash (exact change) only.

We truly hope that you find your experience with Tahoe Youth & Family Services to be helpful and positive.
Should you have any concerns or questions, please do not hesitate to ask.
Information provided on the questionnaire is confidential unless it is dangerous to self or others.

Thank you for choosing Tahoe Youth & Family Services.

Tahoe Youth and Family Services Offices and Drop In Center Locations

Gardnerville Office
1512 Hwy 395, Suite 3
Gardnerville, NV 89410
Ph (775) 782-4202
Fax (775) 782-5055

Gardnerville Drop In Center
1307 Langley, Unit 1
Gardnerville, NV 89460

South Lake Tahoe Office & Drop In Center
1021 Fremont Ave.
South Lake Tahoe, CA 96150
Ph (530) 541-2445
Fax (530) 541-0517

Alpine County Office
Early Learning Center
100 Foothill Rd., Bld. D, Room 5
Woodfords, CA 96120
Ph (530) 694-9459

Text 'tahoeyouth' to 839-863 ● Crisis Line (800) 870-8937
www.tahoeyouth.org

TAHOE YOUTH & FAMILY SERVICES
A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

CLIENT (Youth 10-17 years)
CONFIDENTIAL QUESTIONNAIRE
To be filled out by the client (youth)

Today's Date: _____ /_____ /_____
Client # Office Use Only: _____

PLEASE PRINT

Client Name: _____ **Sex:** ❑ M ❑ F **Age:** _____**DOB** ____ /____ /_____

Place of Birth: _____ **Social Security #:** _____
City State

Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O. Box City State Zip

Home Phone: (_____) _____ -- _____ **Cell Phone: (_____) _____ -- _____**

Can we leave a message? Home ❑ Cell ❑ **Client's Ethnicity/Race:** _____

Client Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Partner ❑ Widowed

Disability: _____**School Name:** _____**School Grade:** _____

PLEASE CIRCLE ONE: Parent / Guardian / Step / Foster

Mother's Name: _____**Age:** _____**DOB**____ /____ /_____

Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O. Box City State Zip

Home Phone: (_____) _____ -- _____ **Cell Phone: (_____) _____ -- _____**

Can we leave a message? Home ❑ Cell ❑ **Ethnicity/Race:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Partner ❑ Widowed

Occupation: _____ **Disability:** _____

PLEASE CIRCLE ONE: Parent / Guardian / Step / Foster

Father's Name: _____**Age:** _____**DOB**____/_____/_____

Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O. Box City State Zip

Home Phone: (_____) _____ -- _____ **Cell Phone: (_____) _____ -- _____**

Can we leave a message? Home ❑ Cell ❑ **Ethnicity/Race:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Partner ❑ Widowed

Occupation: _____ **Disability:** _____

If you do not live with any of the above, with whom do you live?

Name: _____ **Relationship:** _____

Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O. Box City State Zip

Home Phone: (_____) _____ -- _____ **Cell Phone: (_____) _____ -- _____**

Can we leave a message? Home ❑ Cell ❑ **Ethnicity/Race:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Partner ❑ Widowed

Occupation: _____ **Disability:** _____

Who else lives in your home?

NAME	AGE	DOB	DISABILITY

Sisters:

_____

_____

_____

Brothers:

_____

_____

_____

Roommates:

_____

_____

_____

Other:

_____

_____

_____

Have any of the following situations happened in your family? If so, when?

SITUATION	YEAR OCCURRED
❑ Parents' divorce	_____
❑ Custody battle, Is it current ❑ YES ❑ NO	_____
❑ Primary Custodial Parent Name: _____	
❑ Death in the family (Who? _____)	_____
❑ Significant person leaving (Who? _____)	_____
❑ Arrest (Who? _____)	_____
❑ Accident or injury (Who? _____)	_____
❑ Physical or sexual assault	_____
❑ Major family illness (mental or physical)	_____
❑ Recent move	_____
❑ Parent in jail or prison (past____ present____)	_____
❑ Pregnancy, self or parent	_____
❑ Expulsion or suspension from school	_____
❑ Witnessing a crime or being a victim of one	_____
❑ Family member using drugs or alcohol (past ____ present____)	_____
❑ Adoption or Foster services	_____
❑ Other: _____	_____
❑ Have you had a history of cutting or self-harm? Yes ❑ No ❑	_____
❑ Have you had any suicide attempts? Yes ❑ No ❑	_____
❑ Any attempts without hospitalization? Yes ❑ No ❑	_____

❑ Do you have any relatives that have had serious mental or emotional problems? Yes ❑ No ❑

If "yes", please list them:

_____

_____

Are you currently seeking services?

❑ *Private Therapist/Counselor Name:* _____

❑ *Another Agency:* _____

Who referred you here?

❑ Self ❑ *Another Agency:* _____

Has anyone felt concerned about your drinking or using? Yes ❑ No ❑
Do you feel concerned about your use? Yes ❑ No ❑
Do most of your friends use or drink? Yes ❑ No ❑
Have you ever overdosed on drugs or alcohol (alcohol poisoning)? Yes ❑ No ❑
Have you ever been to the emergency room or hospital? Yes ❑ No ❑
Has alcohol or drug use caused problems for you at school, at home, in relationships, or at your job? Yes ❑ No ❑

If yes, please explain: _____

_____

_____

Have you ever used drugs to numb uncomfortable feelings? Yes ❑ No ❑
(boredom, sadness, anxiety, insomnia/sleeplessness)
Have you ever received outpatient treatment for drugs or alcohol use? Yes ❑ No ❑

If yes, when and where? (includes TYFS outpatient, Juvenile Hall or other agency)

_____

Has any family member received treatment for drug(s) or alcohol use? Yes ❑ No ❑

*If yes, when and where?*_____

Have you ever been under the influence of drugs or alcohol? ❑ Yes ❑ No

Have you ever used any of the following? Please be honest.

THIS IS CONFIDENTIAL

Alcohol	Yes ❑	No ❑	How many times? _____	Age first tried: _____
Marijuana	Yes ❑	No ❑	How many times? _____	Age first tried: _____
Spice	Yes ❑	No ❑	How many times? _____	Age first tried: _____
Hallucinogens (LSD, mushrooms, etc.)	Yes ❑	No ❑	How many times? _____	Age first tried: _____
Cocaine	Yes ❑	No ❑	How many times? _____	Age first tried: _____
Crack (Ice)	Yes ❑	No ❑	How many times? _____	Age first tried: _____
Methamphetamines (crank, speed)	Yes ❑	No ❑	How many times? _____	Age first tried: _____
Ecstasy (E)	Yes ❑	No ❑	How many times? _____	Age first tried: _____
Pills (codeine, oxycotin, vicodin, soma, valium, xanax, etc.)				
	Yes ❑	No ❑	How many times? _____	Age first tried:_____
Inhalants, nitrous oxide				
	Yes ❑	No ❑	How many times? _____	Age first tried: _____
Heroin, morphine, methadone				
	Yes ❑	No ❑	How many times? _____	Age first tried: _____
Over the counter medication	Yes ❑	No ❑	How many times? _____	Age first tried: _____
Do you regularly smoke cigarettes?	Yes ❑	No ❑	How much/how often? _____	Age first tried: _____
Would you like help to quit?	Yes ❑	No ❑		

Please check all the behaviors or symptoms that you have experienced.

Now	Past		Now	Past	
❑	❑	Lack of energy	❑	❑	Sneaking out & staying out all night before the age of 13
❑	❑	Feelings of sadness or depression	❑	❑	Running away (how many times?_____)
❑	❑	Irritability	❑	❑	Truant from school before age 13
❑	❑	Trouble sleeping	❑	❑	Expressing severe disgust in others
❑	❑	Difficulty concentrating	❑	❑	Having nightmares or flashbacks about being abused
❑	❑	Changes in eating patterns	❑	❑	Increase in aggressive behavior
❑	❑	Low self-esteem	❑	❑	Major increase or decrease in interest in sex
❑	❑	Feelings of hopelessness or guilt	❑	❑	Anger, rage or fear towards certain people
❑	❑	Thoughts of suicide	❑	❑	Thumb sucking
❑	❑	Lack of caring about anything	❑	❑	Baby talk
❑	❑	Isolation and/or trouble making or keeping friends	❑	❑	Bed wetting
❑	❑	Suicide attempt If yes, when _____	❑	❑	Problems with parent(s)
❑	❑	Feeling restless or nervous	❑	❑	Problems with sibling(s)
❑	❑	Having racing thoughts	❑	❑	Problems with other significant person
❑	❑	Excessive worrying	❑	❑	Academic problems
❑	❑	Confused thinking or mind “going blank”	❑	❑	Attraction to the same sex
❑	❑	Avoiding certain situations or people	❑	❑	Problems adapting from old culture to new
❑	❑	Panic attacks	❑	❑	Mood swings
❑	❑	Poor body image	❑	❑	Change in friends
❑	❑	Perfectionism	❑	❑	Drop in grades and/or extended absences or tardiness
❑	❑	Eating very little or fasting	❑	❑	Poor self-image (“I’m a loser”)
❑	❑	Exercising frequently	❑	❑	Low energy, sleeping more
❑	❑	Overeating	❑	❑	Withdrawal from family and close friends
❑	❑	Vomiting after eating	❑	❑	Hearing voices when not under the influence of drugs or alcohol
❑	❑	Dental problems	❑	❑	Hallucinations when not under the influence of drugs or alcohol
❑	❑	Being “hyper”	❑	❑	Head injury (Date: _____/_____/_____)
❑	❑	Having difficulty paying attention	❑	❑	Sexual abuse
❑	❑	Being fidgety or restless	❑	❑	Physical abuse
❑	❑	Reading or learning disability	❑	❑	Emotional abuse
❑	❑	Problems getting along with others	❑	❑	Witnessed or experienced traumatic event (car crash, earthquake, etc.)
❑	❑	Losing temper often	❑	❑	Nightmares
❑	❑	Arguing with adults and/or refusing to obey authority figures	❑	❑	Feeling numb or detached (“in a daze” or “out of it”
❑	❑	Blaming others for your mistakes	❑	❑	Irritable
❑	❑	Being overly sensitive, “touchy”, vindictive	❑	❑	Unable to remember or recall certain events
❑	❑	Initiating fights	❑	❑	Having access to guns or weapons
❑	❑	Being cruel to animals or people	❑	❑	Stealing things
❑	❑	Deliberately setting fire to or destroying other’s property	❑	❑	Lying, manipulating, or “conning”

Have you ever been arrested? ❑ **Yes** ❑ **No** **Date _____** ***In the last 24 months?*** ❑ **Yes** ❑ **No**

How old were you when you were first arrested, and what were you arrested for?

_____

_____

_____

Are you currently on probation? ❑ **Yes** ❑ **No** ***Is this your first time?*** ❑ **Yes** ❑ **No**

What situation or problem leads you to ask for our services now?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PARENT/GUARDIAN (Youth 10-17 years)
CONFIDENTIAL QUESTIONNAIRE
To be filled out by the Parent/Guardian

Today's Date: _____ /_____ /_____

PLEASE PRINT

Client's (Child's) Name: _____ **Sex:** ❑ **M** ❑ **F** **Age**: _____

DOB: _____ /_____ /_____ **Social Security #** _____ **Insurance:** _____

PLEASE CIRCLE ONE: Parent / Guardian / Step / Foster

Mother's Name: _____**Age:** _____**DOB**____/_____/_____

Address: _____
Street City State Zip

Mailing Address:_____
Street/P.O. Box City State Zip

Home Phone: (_____**)** _____ -- _____ **Cell Phone: (**_____**)** _____ -- _____

Can we leave a message? Home ❑ **Cell** ❑ **Ethnicity/Race:** _____

Marital Status: ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Partner** ❑ **Widowed**

Occupation: _____ **Disability:** _____

PLEASE CIRCLE ONE: Parent / Guardian / Step / Foster

Father's Name: _____**Age:** _____**DOB**_____/_____/_____

Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O Box City State Zip

Home Phone: (_____**)** _____ -- _____ **Cell Phone: (**_____**)** _____ -- _____

Can we leave a message? Home ❑ **Cell** ❑ **Ethnicity/Race:** _____

Marital Status: ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Partner** ❑ **Widowed**

Occupation: _____ **Disability:** _____

The following will allow us to find out more about the problems you are dealing with. By giving these questions your full attention, you will help us better assist you; and it will help you to clarify the issues you want to work on.

Please list some of the problems you are encountering being a parent.

What are some of the current behaviors of your child (or children) that concern you the most?

In what ways have you tried to solve these problems on your own?

What past events do you feel may have contributed to the current problems/concerns?

Please list three goals you would like to accomplish for you, your child, or your family.

1.

2.

3.

Specifically, what do you feel we can do to help you and your child/children accomplish these goals?

_____

_____

_____

_____

_____

_____

Are you currently seeking services?

- ❑ *Private Therapist/Counselor Name: _____*
- ❑ *Another Agency: _____*

Who referred you here?

❑ Self *Another Agency: _____*

Please list any counselors, therapists, psychologists, psychiatrists, and/or doctors that you or your child has seen (evaluations, exams, testing).

Child	Dates of Services	Parent	Dates of Services

Have any of the following situations happened in your family? If so, when?

- ❑ Parents' divorce _____
- ❑ Custody battle, Is it current ❑ YES ❑ NO _____
- ❑ Primary Custodial Parent Name: _____
- ❑ Death in the family (Who? _____) _____
- ❑ Significant person leaving (Who? _____) _____
- ❑ Arrest (Who? _____) _____
- ❑ Accident or injury (Who? _____) _____
- ❑ Physical or sexual assault _____
- ❑ Major family illness (mental or physical) _____
- ❑ Recent move _____
- ❑ Family member in jail or prison (past____ present____) _____
- ❑ Pregnancy, self or parent _____
- ❑ Expulsion or suspension from school _____
- ❑ Witnessing a crime or being a victim of one _____
- ❑ Family member using drugs or alcohol (past ____ present____) _____
- ❑ Adoption or Foster services _____
- ❑ Other: _____ _____
- ❑ Have you had a history of cutting or self-harm? Yes ❑ No ❑ _____
- ❑ Have you had any suicide attempts? Yes ❑ No ❑ _____
- ❑ Any attempts without hospitalization? Yes ❑ No ❑ _____
- ❑ Do you have any relatives that have had serious mental or emotional problems? Yes ❑ No ❑

  If "yes", please list them: _____

Has your child experienced any trauma or stressors? Check all that apply.

- ❑ Accident
- ❑ Severe illness
- ❑ Physical, sexual, or emotional abuse
- ❑ Homeless Past ❑ Present ❑
- ❑ Family member using drugs or alcohol Past ❑ Present ❑
- ❑ Frequent changes in child care Past ❑ Present ❑
- ❑ Learning disabilities Past ❑ Present ❑ Has your child been tested? ❑ **Yes** ❑ **No**

  What was the treatment? _____
- ❑ Separation from parents or primary caregiver

Does your child have a history of cutting, or other self-harm? ❑ **Yes** ❑ **No**

Has your child had any suicide attempts? ❑ **Yes** ❑ **No** Dates: _____

Any attempts without hospitalization? ❑ **Yes** ❑ **No** Dates: _____

Please check all the behaviors or symptoms that you believe your child has experienced.

Now	Past		Now	Past	
❑	❑	Lack of energy	❑	❑	Sneaking out & staying out all night before the age of 13
❑	❑	Feelings of sadness or depression	❑	❑	Running away (how many times? _____)
❑	❑	Irritability	❑	❑	Truant from school before age 13
❑	❑	Trouble sleeping	❑	❑	Expresses severe disgust in others
❑	❑	Difficulty concentrating	❑	❑	Has nightmares or flashbacks about being abused
❑	❑	Changes in eating patterns	❑	❑	Increase in aggressive behavior
❑	❑	Low self-esteem	❑	❑	Major increase or decrease in interest in sex
❑	❑	Feelings of hopelessness or guilt	❑	❑	Anger, rage or fear towards certain people
❑	❑	Thoughts of suicide	❑	❑	Thumb sucking
❑	❑	Lack of caring about anything	❑	❑	Baby talk
❑	❑	Isolation and/or trouble making or keeping friends	❑	❑	Bed wetting
❑	❑	Suicide attempt	❑	❑	Problems with parent(s)
❑	❑	Feeling restless or nervous	❑	❑	Problems with sibling(s)
❑	❑	Having racing thoughts	❑	❑	Problems with other significant person Who? _____
❑	❑	Excessive worrying	❑	❑	Academic problems
❑	❑	Confused thinking or mind “going blank”	❑	❑	Attraction to the same sex
❑	❑	Avoiding certain situations or people	❑	❑	Problems adapting from old culture to new
❑	❑	Panic attacks	❑	❑	Mood swings
❑	❑	Poor body image	❑	❑	Change in friends
❑	❑	Perfectionism	❑	❑	Drop in grades and/or extended absences or tardiness
❑	❑	Eating very little or fasting	❑	❑	Poor self-image (“I’m a loser”)
❑	❑	Exercising frequently	❑	❑	Low energy, sleeping more
❑	❑	Overeating	❑	❑	Lies, manipulates or “cons”
❑	❑	Vomiting after eating	❑	❑	Withdrawal from family and close friends
❑	❑	Dental problems	❑	❑	Hearing voices when not under the influence of drugs or alcohol
❑	❑	Being “hyper”	❑	❑	Hallucinations when not under the influence of drugs or alcohol
❑	❑	Having difficulty paying attention	❑	❑	Head injury (Date: _____/_____/_____)
❑	❑	Being fidgety or restless	❑	❑	Sexual abuse
❑	❑	Reading or learning disability	❑	❑	Physical abuse
❑	❑	Problems getting along with others	❑	❑	Emotional abuse
❑	❑	Losing temper often	❑	❑	Witnessed or experienced traumatic event (car crash, earthquake, etc.)
❑	❑	Arguing with adults and/or refusing to obey authority figures	❑	❑	Nightmares
❑	❑	Often blaming others for his/her mistakes	❑	❑	Feeling numb or detached (“in a daze” or “out of it”)
❑	❑	Overly sensitive, “touchy”, vindictive	❑	❑	Irritable
❑	❑	Initiates fights	❑	❑	Unable to remember or recall certain events
❑	❑	Cruel to animals or people	❑	❑	Has access to guns or weapons
❑	❑	Deliberately sets fire or destroy property	❑	❑	Steals things

Please use the space below for any additional thoughts or concerns you may have regarding your child/children

T A H O E
YOUTH & FAMILY
S E R V I C E S
A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

FEE DETERMINATION

Thank you for choosing Tahoe Youth & Family Services.

We ask that you provide important basic information in order to assess your situation and the appropriate funding source for your services. If we are unable to assist you, we will offer other appropriate referrals in the community.

Individual/Family sessions are 45-50 minutes. Group sessions are 80 minutes in California and 50 minutes in Nevada.

Services will not be provided, nor will verification of services be provided until all requested financial information is received, signed and processed. TYFS requires payment prior to the start of a session. Payments may be made directly to TYFS' Client Advocates.

Yes ❑ No ❑ CLIENT HAS HEALTH INSURANCE (MEDICAID, MEDI-CAL, PRIVATE INSURANCE: _____)
(Please provide a copy of the health insurance card & complete the insurance form on the back.)
Co-Pay Required? Yes ❑ No ❑ Co-Pay Amount: Individual $ _____ Group $ _____
Co-Insurance? Yes ❑ No ❑ Co-Insurance Percentage: _____%

Yes ❑ No ❑ CLIENT QUALIFIES FOR ANOTHER FUNDING SOURCE? (DRYS, SAPTA, TRYS, _____)
Referral Required? Yes ❑ No ❑ Authorization needed? Yes ❑ No ❑

Yes ❑ No ❑ CLIENT WISHES TO PAY CASH FOR SERVICES (cash or card only, must be exact change)
$95 charge per individual session; $30 charge per group session.

Yes ❑ No ❑ CLIENT IS REQUESTING A REPORT BE SENT TO THE COURT BASED ON THE FINDINGS OF A DRUG & ALCOHOL EVALUATION because of a DUI offense, court order, or any other reason; the charge is $100 and is due prior to scheduling the appointment for the evaluation.

Yes ❑ No ❑ CLIENT IS REQUESTING A REPORT BE SENT TO THE COURT BASED ON THE FINDINGS OF A MENTAL HEALTH EVALUATION because of a court order or any other reason; the charge is $125 and is due prior to scheduling the appointment for the evaluation.

Parent or Guardian Signature: _____ *Date:* _____

Insurance Information

CLIENT INFORMATION — PLEASE PRINT CLEARLY

Name: _____ Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Address: _____ Race/Ethnicity:_____

City: _____ State: _____ Zip: _____ 1st Language: □English □Spanish □ Other_____

Date of Birth _____ Check if minor □ (less than 18) Gender: □ M □ F 2nd Language: □English □Spanish □ Other_____

Soc. Sec. # _____

Home Phone: _____ Cell Phone: _____ Can we leave a message? Home □ Cell □

Employer: _____ Work Phone:_____

Referring Agency_____ Referring Agency Phone: _____

PARENT/GUARDIAN INFORMATION

Name: _____ Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Address: _____ Race/Ethnicity:_____

City: _____ State: _____ Zip: _____

Date of Birth _____ Gender: □ M □ F 1st Language: □English □Spanish □ Other_____

Soc. Sec. # _____ 2nd Language: □English □Spanish □ Other_____

Home Phone: _____ Cell Phone: _____ Can we leave a message? Home □ Cell □

Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Plan Phone: _____

Name of Person Insured: _____ Policyholder's DOB _____ Gender: □ M □ F

Soc Sec # _____Employer: _____ Patient Relationship: □Self □Child □Stepchild □Spouse □Other_____

Claims Address: _____ City: _____ State: _____ Zip: _____

Policy ID# _____ Group # _____ Group Name _____

Type of Coverage: □Group □Individual □ Is this a Retiree Plan? □ Yes □ No

Secondary Insurance Company: _____ Plan Phone: _____

Name of Person Insured: _____ Policyholder's DOB _____ Gender: □ M □ F

Soc Sec # _____ Employer: _____ Patient Relationship: □Self □Child □Stepchild □Spouse □Other_____

Claims Address: _____ City: _____ State: _____ Zip: _____

Policy ID# _____ Group # _____ Group Name _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Tahoe Youth & Family Services (TYFS) of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and for all services rendered for me or for my dependents. TYFS will estimate your copay as accurately as possible based on your insurance plan. Your actual share of cost will be determined by your insurance Explanation of Benefits. I authorize TYFS, the therapist and or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above. Rev 10.2017

X_____Date:_____

Signature of Patient (If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above and fill in the information below.

Parent/Guardian Name (Print) _____ Relationship to Patient _____

Monday-Thursday 9a-5p

(closed for lunch from 12p to 1p)

(775) 782-4202 or (530) 541-2445

24-hour voicemail

NO-SHOW and/or LATE APPOINTMENT CANCELLATION POLICY

Please call the office at least 24 hours before your scheduled appointment to make a change or cancellation. Regardless of your fee determination, the following fees will be levied:

1. A fee of $50.00 will be assessed if I do not provide a minimum of 24 hours' notice when I need to cancel or change an appointment. _____ **(Please initial)**
2. A fee of $50.00 will be assessed if I arrive 15 minutes late or more after the scheduled appointment. _____ **(Please initial)**
3. A fee of $125.00 will be assessed if I miss an appointment without contacting the office to cancel the appointment. _____ **(Please initial)**
4. If I miss 2 sessions for unexcused reasons, I may be discharged from services at Tahoe Youth & Family Services' discretion. _____ **(Please initial)**

Please leave a message at ext. 100 if you are unable to reach a staff member by phone.

I understand that Tahoe Youth & Family Services is unable to contact me to remind me about appointments. I will receive an appointment reminder card upon scheduling an appointment to serve as my reminder (unless the appointment is scheduled over the phone.) I understand that I am encouraged to contact Tahoe Youth & Family Services at any time if I need to verify an appointment date and/or time. I understand that if any of the above fees are assessed, my appointments will be removed from the calendar until the fee is paid. At the time of payment, my new appointment will be scheduled based on the current availability.
I understand that insurance companies cannot be billed for these fees therefore they are solely my responsibility.

By signing below, I agree to the above policy and stated fees.

Parent or Guardian Signature: _____ *Date:* _____

TYFS Staff assisting client: _____