TransformED Therapy & Wellness

Combined Intake and Consent Forms

Client Intake Form (English)

Client Name: _____
Date of Birth: _____Age: ____Gender: _____
Parent/Guardian Name (if applicable): _____
Address: _____
Phone Number: _____Email: _____
Preferred Language: _____Interpreter Needed? Y / N

Reason for Referral / Concerns:
_____
_____

Medical History:
Diagnoses (if any): _____
Allergies: _____
Medications: _____

Educational Information:
School/Program: _____Grade: _____
IEP/504 Plan in place? Y / N

Insurance Information:
Primary Insurance Provider: _____
Policy #: _____

Preferred Days/Times for Appointments: _____

Additional Notes:
_____

Formulario de Admisión del Cliente (Español)

Nombre del Cliente: _____
Fecha de Nacimiento: _____Edad: ____Género: _____
Nombre del Padre/Madre/Tutor (si aplica): _____

Dirección: _____
Número de Teléfono: _____Correo Electrónico: _____
Idioma Preferido: _____¿Necesita Intérprete? S / N

Motivo de la Remisión / Preocupaciones:
_____
_____

Historial Médico:
Diagnósticos (si los hay): _____
Alergias: _____
Medicamentos: _____

Información Educativa:
Escuela/Programa: _____Grado: _____
¿Tiene un IEP/Plan 504? S / N

Información del Seguro:
Proveedor del Seguro Médico: _____
Número de Póliza: _____

Días/Horas Preferidas para Citas: _____

Notas Adicionales:
_____

Consent for Treatment

I hereby give consent for myself/my child to receive services at TransformED Therapy & Wellness.
Services may include evaluation, individual or group therapy, consultation, or coaching.
I understand I may revoke this consent in writing at any time.

Client/Guardian Signature: _____Date: _____

HIPAA Notice & Acknowledgment

I acknowledge that I have received and reviewed the Notice of Privacy Practices explaining how my protected health information (PHI) may be used and disclosed.

Client/Guardian Signature: _____Date: _____

Telehealth Consent

I consent to receive services via telehealth, which involves the use of electronic communications to enable health care delivery at a distance.
I understand the potential risks and benefits, and I may opt out of telehealth services at any time.

Client/Guardian Signature: _____Date: _____

Financial Agreement

I acknowledge responsibility for payment of all services provided. I agree to the clinic's policies regarding rates, insurance billing, and missed appointments.
Superbills may be provided for out-of-network reimbursement.

Client/Guardian Signature: _____Date: _____

Consent to Exchange Information

I authorize TransformED Therapy & Wellness to exchange information with the following individuals or agencies for coordination of care:

Name/Organization: _____
Relationship: _____
Phone/Email: _____

Client/Guardian Signature: _____Date: _____

Client Rights & Responsibilities

Clients have the right to receive services that are respectful, confidential, and non-discriminatory.
Clients are expected to attend sessions on time, participate actively, and notify staff of any cancellations.

Client/Guardian Signature: _____Date: _____

Emergency Contact & Crisis Plan

Emergency Contact Name: _____
Relationship: _____Phone: _____

If a mental health crisis arises during services:
• Call 911 or visit the nearest emergency room.
• Contact the Suicide & Crisis Lifeline at 988.
• Reach out to your therapist or care team as soon as possible.

Client/Guardian Signature: _____Date: _____

Upload Instructions

Please upload your completed intake packet using our secure encrypted portal:

[Upload Link or QR Code Placeholder]

Alternatively, you may email your forms to: intake@transformedtherapywellness.com or bring them in person to your first appointment.