NIALife
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PATIENT INFORMATION

Patient Name (Last) (First)			Home Phone
Address.		Cellular Number: Email Address:	
City/State:	Zip Code	D.O.B	Soc. Sec. #
Race African American/Black Asian/Pacific Islander Hispanic/Latino Caucasian Native American Other:_____	Gender: Gender Identity:	Marital Status: Single Married Divorced Separated Widow(er)	Age:
Employer/ School:			(If applicable) Grade:

RESPONSIBLE PARTY

Name of Parent/Guardian	Phone Number if Different from Above	
Address (If different from above)	Employer:	Work Number:
Relationship to the Patient Mother Legal Guardian Foster Parent Father Family Member Other:_____	Occupation:	Marital Status: Single Divorced Separated Widow(er) Married

INSURANCE INFORMATION

Medicaid Yes No	Medicaid Number:	
Primary Insurance Company Name:	Person Carrying Insurance:	
Is Insured Through Employer? Yes No	Employer:	
Insured Birthdate:	Patient's Relationship to the insured	
Policy Number:	Group Number:	Insured Social Security Number:
Secondary Insurance Company Name:	Person Carrying Insurance:	Is Insured Through Employer? Yes No

Patient Information Form

NIALife Center for Counseling, LLC
14635 S. Harrells Ferry Rd. Suite 3a Baton Rouge, LA 70816
225-349-8984 fax: 844-269-9818
info@nialife.org, www.nialifecounseling.com

Employer:	Insured Birthdate	Patient's Relationship to the insured
Policy Number:	Group Number:	Insured Social Security Number
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize release of any Medical Information to process claims related to my treatment and authorize Payment of medical benefits to this service provider. Signed **X**		Date:

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Patient Name:

Office Use Only: Patient Number

ADMISSIONS AGREEMENT

Initial each paragraph agreed to:

I _____ (client or parent/legal guardian if under 18) give my consent and agree to the following:

_____Request admission for myself, child or ward to NIALife Center for Counseling, LLC for periodic services and treatment, understand that I will not be deprived of my legal rights and responsibilities and that I can discharge myself, child or ward from NIALife Center for Counseling, LLC upon written and/or verbal notice to the Administrator. I have received a copy of my Bill of Rights developed by Magellan Behavioral Health and as written in policy and has been explained to me. In addition, I acknowledge that I have received information concerning Client's Rights and the Grievance Procedures.

_____ I acknowledge that the confidentiality regulations have been explained to me. I understand that no employee, contractor or visitor to NIALife Center for Counseling, LLC can divulge information to any unauthorized person without my knowledge and written consent. I also understand that divulging confidential information to unauthorized persons is a misdemeanor and is subject to civil penalties. I understand it is the policy of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services that as a client in one of its agencies, I (child or ward) shall receive appropriate treatment and continuity of care. In order to accomplish this, information may be shared between treating agencies for quality care without consent in accordance with a. s. 122C-52 through 122C-56, to comply with G.S. 122C-54 (h), this agency is required to disclose confidential information for the purpose of complying with mandatory reporting and disclosure law relevant to the suspicious of abuse, neglect or dependency of children.

_____ I understand that NIALife Center for Counseling, LLC , its personnel, contractors and client's attending physicians will NOT be held responsible for any accidents or the deterioration of the client's condition while out in the community and in any of the above person's care.

_____ I have received my Handbook and have been orientated to NIALife Center for Counseling ,LLC. I agree to follow the policies and procedures of the organization. I understand my rights and responsibilities as a recipient of services and that failure to fully participate as described by the regulations of NIALife Center for Counseling, LLC may result from discharge from the agency.

____ I was educated and provided information by NIALife Center for Counseling, LLC Providers regarding my or my child's diagnosis and treatment.

Patient Name:

Office Use Only: Patient Number

RESTRICTIVE INTERVENTION AND/OR PHYSICAL RESTRAINTS

_____I understand that NIALife Center for Counseling, LLC does not use physically restrictive methods such as seclusion and restraints. In the instance, a client becomes aggressive and is in danger of harming themselves or others, 911 emergency services will be notified.

_____ I authorize NIALife Center for Counseling, LLC to provide first aide assistance to the client while in the care of its team members.

_____ I will be notified of any serious illness, any changes in medical treatment.

_____ I do not want visits or contact with the following people:

_____

_____

_____

_____

SIGNATURES:

_____

Patient Name Date

_____

Parent/Guardian (if applicable) Date

_____

Refusal to Sign Date

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CONSENT FOR USE, DISCLOSURE AND/OR RELEASE OF PERSONAL AND HEALTH INFORMATION		
Patient Last Name	First Name	Middle Initial
Date of Birth	Telephone Number	
Address	City, State,	Zip Code
Parent/Guardian/Caretaker Name (If applicable)	Relationship to Patient	

Office Use Only:
Patient Number: _____

I. PERSON OR AGENCY ***REQUESTING*** THE INFORMATON The persons or agency can request the patient's personal, health and/or education information. (The information to be released is described in section III, below.)		
Agency Name: NIALife Center for Counseling,LLC		
Address: 2929 Millerville Rd. Suite E	City/State Baton Rouge, LA	Zip Code 70816
Agency Contact and Title Ebony Christophe, LPC/Clinical Director		
Telephone Number: 225-349-8984	Fax Number 844-269-9818	

II. PERSON OR AGENCY ***PROVIDING*** THE INFORMATON The persons or agency may release the patient's personal, health and/or education information; (The information to be released is described in Section III below.)		
Agency Name:		
Address:	City/State	Zip Code
Agency Contact and Title		
Telephone Number	Fax Number	

III. INFORMATION THAT MAY BE RELEASED:
The person or agencies marked in Section I above may view, copy, release and exchange the information or records marked below. (Please check all that apply to the patient's needs now and in the future.) This information may be shared verbally, in writing and/or by email or fax:

NIALife Center for Counseling, LLC
2929 Millerville Rd. Ste. 4A Baton Rouge, LA 70816
225-366-9605
info@nialife.org

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Medical Information, including but not limited to operative, emergency, radiology, consultations, progress notes Screening Information Developmental Information Psychological Records Speech/Language Other:_____	Educational Records Developmental Mental Health/

SPECIFIC AUTHORIZATIONS: The following information will not be released unless you specifically authorize it by marking the relevant box below:

I specifically authorize the release of information pertaining to mental health diagnosis or treatment or psychological information (Welfare & Institutions Code (SS5328, et seq)

THE PATIENT'S INFORMATION MAY BE USED TO:

1. Get more services
2. Allow various professionals to understand the patient's development.
3. Allow various professionals to help coordinate medical and non-medical services for the patient.

VOLUNTARY: I know that I do not have to sign this consent form. I can refuse to sign this consent form and it will not affect the services I and/or my child gets from this agency.

LENGTH OF TIME: This consent will be valid from the date I sign this form until _____ (date). If no date is entered, the form will be valid for one year after the date that I sign the form.

WITHDRAWAL: I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to the person or agency in Section I. The withdrawal will be valid as soon as the person or agency gets my note, but will not apply to information that has already been shared after I sign the consent form.

SHARING OF INFORMATION: I know that my information may be shared more than once by the persons and/or agency in Sections I and II. The information may no longer be protected by the HEALTH Insurance Portability and Accountability Act of 1996 (HIPAA). It may still be protected by other state and federal laws.

COPY: A copy of this consent form will be as good as the original. I know that I have a right to get a copy of this consent from if I ask for one.

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Print Full Name	Signature
Relationship to Patient (If applicable)	Date

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info@nialife.org

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PATIENT EMERGENCY CONTACT FORM	
Patient Name:(Last) (First) (M.I)	Date of Birth:
Parent/Guardian Name (If applicable):	Telephone Number:
Patient Address:	
Emergency Contact Name:	Telephone Number:
Relationship to Patient:	Alternate Telephone Number:
Emergency Contact Address:	

I_____, give permission to NIALife Center for Counseling, LLC staff to contact the above listed person at the telephone number and address above in case of a medical or mental health emergency. I understand that personal information about the patient's medical treatment and care may be shared with the above named emergency contact person.

The permission to contact the emergency contact person listed above may be revoked at any time and immediately upon discharge. Consent to contact the above person lasts up to one year from the date of this signed release.

Patient (If older than 21) Date

Parent/Guardian Date

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225-366-9605
info@nialife.org

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HEALTH & SAFETY PLAN		
Patient Name:	Date:	(Office Use Only) Patient Number:
Parent/Guardian Name (If applicable)		

All staff are trained and certified in first aid and cardiopulmonary resuscitation (CPR) annually. Staff shall **in no instance** administer or manage any medications, prescription or over the counter to any patient or family member. Staff is not liable for any harm or injury which may occur during an attempt of first aid or CPR.

PART 1. HEALTH & INJURY PLAN

In an event where staff is present, there is no medically certified professional present and a patient is seriously ill or hurt the following plan shall be implemented.

- Staff shall act as a first aid provider
- Staff shall either call 911 emergency personnel from his or her required work cellular phone or instruct the nearest responsible adult to contact 911 emergency personnel using the required work cellular phone.
- Staff will perform an initial and ongoing assessment of the injured or ill person
- Staff shall perform first aid or CPR only within the scope of the professional's certification until medical help arrives.
- Once medical professionals arrive, staff will contact the Executive Director to provide an oral report of the events.
- A written report of events will be completed and filed the following business day.

In an event where a staff is not present and there is no medically certified professional is present the following plan shall be implemented by the adult responsible for the patient.

- The care giver shall contact 911 emergency personnel immediately.
- The care giver shall provide an initial and ongoing assessment of the ill or injured person.
- The care giver should only provide first aid or CPR if certified or trained within a year of the event.
- Once medical help has arrived, if the care giver is not the legal guardian, the care giver should contact the legal guardian by telephone
- If the care giver is the legal guardian contact a staff member at 225-366-9605 once medical help arrives.
- Staff shall provide an oral report to the Executive Director immediately.
- A written report shall be completed and filed the following business day.

I have read and understand the health and injury plan. I accept and agree with the responsibilities of the organization and will implement the above plan when necessary. If I choose not to follow the health and safety plan, I will hold harmless the organization, its employees or assigned agents for any and all damages or liabilities which may occur as a result of voluntarily not following the said plan.

Parent/Guardian Signature (If applicable):	Patient Signature (If over 18):

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PART 2. DISASTER & EVACUATION PLAN

Staff assumes responsibility for the ongoing education of their patients and families regarding emergency preparation of a disaster of natural or manmade form. These disasters include hurricanes, tornados, floods, terrorism, fire, winter weather, heat and the release of hazardous materials.

The organization is responsible for providing a list of community resources to contact in case of a natural disaster to the families annually.

- Staff will first ensure the safety of themselves, family and property within 24 hours of an announcement of a disaster by the Louisiana Department of Homeland Security and Emergency Preparedness.
- Within 24 hours of an announcement of a disaster by the Louisiana Department of Homeland Security and Emergency Preparedness, staff will contact patient and/or parent/guardian of the patient.
- Parent/Guardian and/or patient shall contact the Executive Director, Behavioral Health Professional or Behavioral Health Specialist
- In the event of an emergency evacuation the patient and/or parent/guardian must keep with them the following:
    1. All medications in a water proof container
    2. Copy of the patient's birth certificate in a water proof container
    3. Bottled water
    4. Identification
    5. Telephone numbers
    6. Flash lights
    7. Batteries
    8. Battery Powered Radio
- Staff shall provide a list of current shelters, food banks, evacuation routes, etc. that are available in the family's community.
- Within 24 hours of the end of the disaster or communication is available, contact staff to identify your location and safety.

In the event you are unable to contact a staff member, please follow all directions from the federal, state, and local government.

List 2 address in the event an evacuation is mandated during a disaster

1._____

____ Address City/State Zip Code

2.

_____

____ Address City/State Zip Code

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List 2 telephone numbers to contact in the event of a disaster

1._____
2._____

I understand, accept and agree with the responsibilities of myself and NIALife Center for Counseling, LLC in the event of a disaster. I will accept all responsibility if I do not follow the disaster plan outlined above.

Patient Signature (if over 18) Date

Parent/Guardian Signature (if applicable) Date

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info@nialife.org

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Member Name (First, Last Name):
Member ID #:

Member DOB:

Healthy Louisiana Mental Health Rehabilitation Member Choice Form

Member Information: I am requesting services from a mental health rehabilitation (MHR) provider. I understand that I have the right to choose an agency to provide services to me or my child. I understand that I may only receive MHR services from **one provider** unless my health plan makes an exception. I may change providers if I am not satisfied with the services.

If assistance is needed with finding an MHR provider, review the list of providers located at your health plan's website below or call your plan for assistance.

1. **Aetna**: https://www.aetnabetterhealth.com/louisiana/find-provider or call 1-855-242-0802 Hearing impaired TTY/TDD 711
2. **Amerihealth Caritas Louisiana**: http://www.amerihealthcaritasla.com/member/eng/tools/find-provider.aspx or call 1-888-756-0004; TTY 1-866-428-7588
3. **Healthy Blue**: https://www.myhealthybluela.com/la/care/find-a-doctor.html or call 1-844-227-8350 (TTY 711)
4. **Louisiana Healthcare Connections**: https://providersearch.louisianahealthconnect.com/ or call 1-866-595-8133 (Hearing Loss: 711)
5. **United Healthcare Community**: http://www.uhccommunityplan.com/la/medicaid/healthy-louisiana.html or call 1-866-675-1607 TTY: 1-877-4285-4514

The provider that I have freely selected to deliver MHR services to me or my child is:

Provider Name:	**NIALIFE CENTER FOR COUNSELING, LLC.**
Provider Phone Number:	**OFFICE: (225) 349-8984** **FAX: (844) 269-9818**
Provider Contact Name:	**EBONY CHRISTOPHE, MAPC, LPC.**
Provider Address:	**14635 S. HARRELL'S FERRY RD. SUITE 3A, BATON ROUGE, LA 70816**

By signing the form below, I understand that I have chosen to receive services from this MHR provider and I acknowledge that it is my responsibility to notify my previous provider so they can coordinate my care with my new provider. I understand that I am free to choose any MHR provider in my health plan's network.

Member/Legal Guardian Signature **Date**

Printed Member/Legal Guardian Signature **Date**

Providers Information: A Member Choice form is required prior to receiving any mental health rehabilitation services. This form requires member/legal guardian signature, date, identified provider with telephone and contact name. The provider is responsible for coordinating the transition of care with the member's previous provider prior to starting services.

E C [illegible] LPC

Provider's Signature **Date**

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Orientation to Behavioral Health Rehabilitation Program

Patient Name:	(Office Use) Patient Number:

Included in your orientation handbook are the following policies, forms and expectations:

- Identification Form
- Brochure
- Code of Ethics
- Patient Rights & Responsibilities
- Crisis procedures with telephone numbers
- Complaints, grievances and appeals procedures & forms
- Ways in which input can be given (Satisfaction Survey)
- Confidentiality Policy
- Abuse & Neglect Policy
- Seclusion & Restraint Policy
- Behavioral Health Rehabilitation Program Description
- Behavioral Expectations of the Person Served
- Discharge Criteria
- Transition Criteria and Procedures
- Response to the identification of potential risk to the person served
- Standards of professional conduct related to services
- Requirements for reporting and/or mandated person served
- Fee Schedule
- Health & Safety Policies
- Rules & Expectations
- Familiarization with the premises included emergency exits, fire suppression equipment and first aid kits
- Identification of the purpose & process of the assessment
- A description of the person centered plan

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info@nialife.org

- Potential course of treatment
- Motivational Incentives
- Expectations for legally required appointments, sanctions or court notifications
- Identification of the person responsible for service coordination

I have received my orientation handbook; have been orientated and agree to follow the policies and procedures of the behavioral health rehabilitation program. I understand my rights and responsibilities as a recipient of services and that failure to fully participate as described by the behavioral health rehabilitation program may result in discharge from treatment.

Patient Signature (If over 18):	Date
Parent/Guardian Signature (If applicable):	Date
Person Responsible for Coordinating Services Signature:	Date

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Child & Adolescent Behavioral Health Rehabilitation Program
Parent/Guardian Treatment Participation Agreement

Patient Name:	(Office Use)Patient Number:
Parent/Guardian Name (Print)	

The Child & Adolescent Behavioral Health Rehabilitation Program requires you as the parent/guardian to be involved and active in the treatment process of your child. In order to receive services in the Child & Adolescent program, we are required by the Louisiana Department of Health and Hospitals to have the full participation of the patient and parent/guardian. Our Child & Adolescent Behavioral Health Program works from a family systems model. We incorporate the entire family in the treatment process. You, as the parent/guardian, are an important part of the process. Therefore, we ask you to read this agreement carefully.

As a parent/guardian of a child being provided services by the Child & Adolescent Behavioral Health Rehabilitation team, I agree to participate in treatment in the following ways and understand that failure to do so may result in the discharge of my child from services due to noncompliance.

1. I agree to receive services from the Child & Adolescent Behavioral Health Rehabilitation team to include:
    - Licensed Behavioral Health Professional
    - Behavioral Health Professional
    - Behavioral Health Specialist
    - Licensed Psychiatrist/Advanced Practice Nurse Practitioner
    -
2. I will make my child available for weekly sessions with a member of the treatment team for counseling, psychosocial skills training and community psychiatric support & treatment.
3. I understand failure to participate in sessions in a safe, sanitary and private environment may cause discharge due to noncompliance.
4. I, the parent/guardian, agree to communicate weekly with a member of the treatment team in regards to my child's treatment progress.
5. I agree to participate in treatment team meetings with my child and the treatment team once every 6 months and as needed to review treatment progress and update information.
6. I will maintain a current copy of my child's treatment plan and crisis plan and understand I may ask for a copy at any time.
7. I understand that my child has been diagnosed with a mental health disorder.
8. I will notify the Child & Adolescent Behavioral Health Rehabilitation Program of any changes to my contact information to include address, telephone numbers or email address.
9. I understand my rights of confidentiality as well as limits to confidentiality regarding my child's services.
10. I understand my rights as a person served by the Child & Adolescent Behavioral Health Rehabilitation Program.
11. I will treat the staff of the Child & Adolescent Behavioral Health Rehabilitation Program with respect and abide by the policies, procedures, regulations, and rules of the organization.
12. I understand I may discontinue services for my child at any time with verbal or written notification.

Parent/Guardian Signature: Date:

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Patient Name:	Date of Birth:	
Address:	Telephone Number:	
Parent/Guardian Name: (If applicable):		
Primary Care Physician (PCP):	Telephone Number:	Fax Number:
PCP Address:		
Psychiatrist:	Telephone Number:	Fax Number:
Psychiatrist Address:		
Other Physician:	Telephone Number:	Fax Number:
Physician Address:		
Please List All Medications:		
Please List All Current Medical and Psychological Diagnoses:		
Please List All Allergies/Adverse Reactions to Medications:		
Identify any important medical information:		
Signature:	Date:	

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225-349-9818
info@nialife.org, www.nialifecounseling.com

Patient Name: Patient Number:

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATIONS

Your physician has prescribed the psychotropic medication(s) listed below. In order to make an informed decision, you must be provided with information (verbal and/or written) including the following:

1. The nature of your psychiatric condition (diagnosis).
2. The reasons for taking such medication(s), include the likelihood of improving or not improving without such medication(s).
3. The name, dosage, frequency, route of administration and duration of prescribed medication(s).
4. The possible side effects of the medication(s) known to commonly occur and may possibly cause birth defects.
5. Duration and continuation of medication(s) will be discussed with you and your treating Psychiatrist/Nurse Practitioner during each visit

£Name of Medication: ______________ Dosage: Frequency up to: mg/day	By Mouth
	Duration: ¨ 24 mos ¨ 12 mos ¨ Other _____
£Name of Medication: ______________ Dosage: Frequency up to: mg/day	By Mouth
	Duration: ¨ 24 mos ¨ 12 mos ¨ Other _____
£Name of Medication: ______________ Dosage: Frequency up to: mg/day	By Mouth
	Duration: ¨ 24 mos ¨ 12 mos ¨ Other _____
£Name of Medication: ______________ Dosage: Frequency up to: mg/day	By Mouth
	Duration: ¨ 24 mos ¨ 12 mos ¨ Other _____
£Name of Medication: ______________ Dosage: Frequency up to: mg/day	By Mouth
	Duration: ¨ 24 mos ¨ 12 mos ¨ Other _____
£Name of Medication: ______________ Dosage: Frequency up to: mg/day	By Mouth
	Duration: ¨ 24 mos ¨ 12 mos ¨ Other _____
£Name of Medication: ______________ Dosage: Frequency up to: mg/day	By Mouth
	Duration: ¨ 24 mos ¨ 12 mos ¨ Other _____

Reasonable Alternative Treatments Available, if any:

¨ Psychotherapy ¨ Psychosocial Skills Training ¨ Community Psychiatric Support & Treatment
¨ Family Therapy ¨ Group Therapy ¨ Other: ________________

Your signature below acknowledges that:

- The above medication(s) and treatment have been adequately discussed with you and should be taken only as prescribed.
- You have received all the information you desire concerning such medication(s) and treatment.
- I have been educated on medications prescribed and had an opportunity to consult with the prescriber regarding the specific benefits and side effects of prescribed medicine(s). **Patient/Parent/Guardian initials:** ______
- I hereby give my consent to treatment with this medication. I understand that I may seek additional information, and that I may withdraw this consent at any time by stating my intention to any member of the treatment team.

Patient Signature*:____ Date:______________

Parent/Guardian Signature*(If Under 18):____ Date:______________

Clinician Signature: ____ Date: ______________

Physician/Nurse Practitioner Signature:____ Date:______________

**Unable to obtain Patient/Parent/Guardian signature – Document Reason:*

_____

_____

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Office: 225-349-8984 Fax: 1-844-269-9818 Email: info@nialife.org

MAGELLAN HEALTH SERVICES
MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

Members have the right to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive information in a language they can understand.
- Receive a clear explanation of their condition and treatment options.
- Receive information about Magellan, its providers, programs, services and role in the treatment process.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- If asked, Magellan will act on the member's behalf as an advocate.*
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care made on the basis of treatment needs.
- Receive information about Magellan's staff qualifications and any organization Magellan has contracted with to provide services.*
- Decline participation or withdraw from programs and services.*
- Know which staff members are responsible for managing their services and from whom to request a change in services.*

Statement of Members' Responsibilities

Members have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers and Magellan information that they need. This is so providers can deliver quality care and Magellan can deliver appropriate services.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.
- Let Magellan and their provider know if they decide to withdraw from the program.*

* This standard is required for our *Condition Care Management* (CCM) products.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

_____

Provider Signature Date

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Patient Name:	Date of Birth:

To: _____

NIALife Center for Counseling is a behavioral health rehabilitation organization licensed by the Louisiana Department of Health and Hospitals and the Louisiana Office of Behavioral Health and accredited by Commission on Accreditation of Rehabilitation Facilities (CARF) to provide psychiatric care, medication management, counseling, skills training, support and advocacy to children, adolescents and adults diagnosed with a mental illness. Our services are provided by licensed medical practitioners, licensed behavioral health professionals, master's degreed behavioral health professionals and experienced, professionally trained bachelor's degreed behavioral health specialists.

The parent/guardian of _____ gives permission for staff to provide these services weekly to the client named above during school hours and to exchange information regarding the client's treatment and progress with school administration. Consent to exchange information expires one year from the date of signature below or with the expressed consent of the parent/guardian at any time during treatment.

Staff will provide a pictured identification badge and sign into the school building upon each visit. Our staff agrees to abide by all rules, policies and procedures regulated by the school while visiting the campus.

Parent/Guardian Signature Date

*If you have any questions or concerns regarding our services or staff please contact Program Coordinator at the telephone number below. For more information regarding our services you may also email us at info@nialife.org.

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