Colleen M. Cavanagh, MS, LCSW, LLC
311 Claremont Avenue
Montclair, NJ 07042
Phone: (201) 362-5793 Fax: (201) 963-6504

Adolescent Intake Client Information Form:

Child: _____

Child Birth Date: _____ Age: _____ Sex: M F

Home Address: _____

_____

City: _____ State: _____ ZIP Code: _____

Parent/s: _____

_____

Child School/Grade: _____

School Contact (Name and Number): _____

Consent to speak to school contact, if requested: Yes _____ No _____

Signature of parent for consent to speak to school: _____

Child Pediatrician (Name and Number): _____

_____

Consent to speak to Pediatrician, if requested: Yes _____ No _____

Social Security: _____ Home Phone No. _____

Parent phone: _____Is it ok to text phone number? Yes ___ No ___

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Phone texting is limited to scheduling purposes only.

Parent Occupation/Employer: _____

Parent Occupation/Employer: _____

Work Phone No._____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Referred to Provider by: _____

Email Address: _____

Alternative Email Address: _____

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PLEASE READ CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. I hereby consent to treatment by Colleen Marie Cavanagh, LCSW, LLC. I have received written notice of my rights under HIPAA and the limits of confidentiality under the law. I understand that I have a right to discontinue or refuse treatment at any time but remain responsible for any outstanding fees at the time of terminating therapy. **I understand that I am required to provide no less than 24 hours notice for cancellations, and cancellations with less than the required notice may result in my being responsible for paying the FULL FEE for the missed session**. It is at the discretion of Colleen Marie Cavanagh, LCSW, LLC to waive the cancellation fee on a case by case basis. I understand that if I am late for my appointment, it will still end at the designated time.

PARENT (LEGAL GUARDIAN) SIGNATURE PRINT NAME

DATE

PARENT (LEGAL GUARDIAN) SIGNATURE PRINT NAME

DATE

WITNESS SIGNATURE PRINT NAME

DATE

"There is hope in the storytelling. There is healing in the connection."