PRIVATE PAY INTAKE FORM

Please fill in the following information and bring it to your scheduled orientation

Date: _____ Are you the: □ Custodial Parent □ Non-Custodial Parent □ Other

Name: _____ Date of Birth: _____

Current Address: _____

Street City State

Primary Phone Number: _____ E-mail: _____

Best time to contact you?_____ May we leave a message _____

Employer: _____ Occupation: _____

□ Parent 2 □ This parent is aware they are being contacted (check if yes)

Name: _____ Date of Birth: _____

Phone Number: _____

PARENT DEMOGRAPHIC INFORMATION

Marital Status □ Single □ Married □ Partnered □ Divorced □ Widow(er) □ Separated

Race or Ethnic Group: □ African American □ Asian □ Caucasian □ Hispanic
□ American Indian □ Other (*please specify)*

Education Completed: **Served in the military:**

Do you live in Mille Lacs County? _____ Number of people living in your home:

SCHEDULING AND VISITATION/EXCHANGE INFORMATION

(Visits will be scheduled according to what days and times are available on the Visitation Center Schedule and the days and times BOTH parties are available.)

What days/hours do you work? _____

Possible days/times for visitation/exchanges: _____

Explain past visitation or exchange arrangements: _____

Date you last visited with child(ren): _____

□ I have had no or little contact with child(ren).

HEALTH INFORMATION

List any health-related illnesses/conditions/disabilities for adults and children involved in supervised visitation services.

Person's Name: _____

Allergy/Illness/Disability_____

HOUSEHOLD INFORMATION

Please list all children living in the home who will be participating in supervised visits or neutral exchanges.
List additional children involved in supervised visitation or neutral exchanges on the back of this page.

Child 1:

Name: _____ Date of Birth: _____

Ethnicity:

Caucasian Asian African American Native American

Pacific Islander Latin/Hispanic Other _____

Child 2:

Name: _____ Date of Birth: _____

Ethnicity:

Caucasian Asian African American Native American

Pacific Islander Latin/Hispanic Other _____

Child 3:

Name: _____ Date of Birth: _____

Ethnicity:

Caucasian Asian African American Native American

Pacific Islander Latin/Hispanic Other _____

I hereby certify the information on this intake form is true and accurate to the best of my knowledge. I agree to allow Arrows Family Services to contact emergency medical personnel (911) if needed for my child(ren) or myself. I have listed all medical concerns to which emergency personnel should be made aware.

Signature _____ Date: _____

Intake form reviewed by: _____ Date _____

AUTHORIZATION FOR RELEASE AND EXCHANGE OF PRIVATE INFORMATION

I, _____, hereby authorize the release and exchange of confidential information regarding the following persons: **Self DOB**: __/__/__

Minor: _____ DOB: ___/_/_

Minor: _____ DOB: ___/_/_

Minor: _____ DOB: ___/_/_

Minor: _____ DOB: ___/_/_

I authorize Arrows Family Services or its designees and/or legal counsel to provide / obtain / and exchange verbal and/or written information to the following individual or entity:

Name Individual or Entity: _____

FOR THE PURPOSES OF:

sharing information and documentation regarding supervised visits and/or parent education

SIGNATURE OF INDIVIDUALS AUTHORIZING RELEASE OF INFORMATION: (I understand this authorization is voluntary and I may refuse to sign this release form)

(Signature) _____ (Printed Name) _____

(Relation to Minor) _____ (Date) _____

EXPIRATION NOTICE: *Unless otherwise revoked, this authorization will expire one (1) year from the date of signing.* ***WITHDRAWAL OF***

AUTHORIZATION NOTICE: *I understand I may revoke this authorization at any time by submitting written notification to Arrows Family Services. I understand that such a revocation will not have any effect on information already used or disclosed by Arrows Family Services before receiving my written notice of revocation. I may inspect and receive a copy of the information to be used and disclosed pursuant to this release form.* ***REDISCLOSURE NOTICE:*** *I understand that these records are protected under state and federal privacy laws and cannot be disclosed without my written consent unless otherwise provided for by state or federal law. If neither federal nor Minnesota privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Minnesota privacy law. I understand that the organizations specified in this release will use my data in accordance with Minnesota Government Data Practices Act (MGDPA), and the federal Health Insurance Portability and Accountability Act (HIPAA). These laws protect your privacy, but also allow us to share information about you with others if a law requires it. These laws require us to keep your health information private and to give you notice of our legal duties and practices to protect private and confidential information. Arrows Family Services is required to abide by the terms of the Privacy Notice currently in effect.*