CORNERSTONE HEALTH

Child & Adolescent Intake Packet

Welcome to Cornerstone Health Counseling

Cornerstone Health Counseling is committed to treating the whole person. We provide counseling services to nurture you to become a healthy individual in body, soul, and spirit. Clinic services are provided by licensed psychologists, master level clinicians, individuals with master's degrees seeking licensure, and students in graduate programs. The students and non-licensed clinicians are under supervision by on-site clinical supervisors. Information regarding your chosen therapist's qualifications will be provided. Clinic services do not include forensic work. Court-ordered services will only be provided at the discretion of the therapist. Additional fees will be added for any court-related services. Such fees will be provided if approved. For questions about your treatment, you may call us at (907) 522-7080.

Please initial on each line, indicating that you have read the paragraph.

_____ **CONFIDENTIALITY:** We place a high value on client privacy; all records are confidential. Recording devices in session are only authorized if a prior mutual agreement between clinician and client has been established. We may bring client cases to case consultation or consult with another therapist within the agency. Should we do so, no name or other identifying information will be shared. You may give written permission for your therapist to share information with other individuals like medical or psychiatric providers, school personnel, case workers, or family members. Legal requirements specify certain conditions in which it is necessary for us to disclose your name and/or your treatment. These requirements are as follows:

1. **If we believe you are a danger to yourself or others.**
2. **If we become aware of any involvement you have in the abuse of children, elderly, or disabled persons.**
3. **If we are ordered by a judge or court to release your records.**

_____ **FEES:** I understand that if my therapy hour extends over the normally scheduled time, I may be responsible for a larger co-pay or co-insurance and anything else that my insurance will not cover. Fees also apply to the preparation of assessment and other reports, telephone conversations, consultations, or meetings you have authorized as part of your counseling process. We will bill your insurance carrier(s) as a courtesy. Insurance co-pays and co-insurance are due at the time of visit. If your insurance does not pay, you are responsible for your bill. Our billing is done through Spectrum Medical Billing Services, LLC and their phone number is (907) 440-5900.

_____ **NO-SHOWS/LATE CANCELLATIONS**: If you are unable to attend scheduled session, please give us a 24-hour notice of cancellation. The fee for an unkept appointment/late cancellation is $100. After three no-shows or late cancellations, you may be subject to termination of services. If you are booked in a standing appointment slot and you are finding it difficult to consistently keep those standing appointments, please let us know. We reserve the right to remove those standing appointments from the schedule to free up those appointment slots, and we are happy to schedule appointments one at a time for you.

I hereby give consent to Cornerstone Health Counseling to administer appropriate treatment. I also consent to the release of information for insurance purposes from my insurance company to Cornerstone Health Counseling. This signed consent shall remain in effect until it is revoked by the client or guardian, at which time written notice must be given to withdraw existing consent. I am responsible for all charges generated for services rendered including services not covered by my insurance company.

_____ _____

Signature of Client or Authorized Representative **Date**

_____

Printed Name of Client

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Client Demographic Sheet (Child & Adolescent)

General Information (Client)

First Name: _____ M.I.: _____ Last Name: _____ DOB: _____ Age: _____

Gender: _____ Social Security Number: _____

Home Address: _____ City: _____ State: _____Zip: _____

Employed: □ No □ Full time □ Part time □ Self □ Student Occupation: _____

How did you hear about us? _____

Parent/Guardian Information:

Mailing Address: _____ City: _____ State: _____Zip: _____

Full Name: _____ Relationship: _____ Phone #: _____

Email address: _____

Full Name: _____ Relationship: _____ Phone #: _____

Email address: _____

Insurance Information: □ I do not wish for my insurance to be billed. □ I do not have insurance.

PRIMARY: _____ ID #_____ Group #_____

Policy Holder Name: _____ DOB: _____

Relationship to Client: □ Self □ Spouse □ Parent □ Other: _____

SECONDARY: _____ ID #_____ Group #_____

Policy Holder Name: _____ DOB: _____

Relationship to Client: □ Self □ Spouse □ Parent □ Other: _____

TERTIARY: _____ ID #_____ Group #_____

Policy Holder Name: _____ DOB: _____

Relationship to Client: □ Self □ Spouse □ Parent □ Other: _____

_____ _____

Signature of Client or Authorized Representative **Date**

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Child and Adolescent Intake History

Child's Family History

Who does the child currently live with? _____

Child's birth order(circle): 1 2 3 4 5 6 7

Ages of siblings: ____ ____ ____ ____ ____ ____ ____

Church Attended (if applicable): _____
Cultural beliefs: _____
Has the child been separated from their biological father or mother? □ Yes □ No
If yes, for how long and under what circumstances?

_____

Child's Social History

How many close friends does your child have? _____ If possible, please provide name(s), age(s), gender(s) and their relationship (i.e. school friend, teammate, neighbor, etc.)

Name: _____ Age: _____ Gender: _____Relationship: _____

Name: _____ Age: _____ Gender: _____Relationship: _____

Name: _____ Age: _____ Gender: _____Relationship: _____

Does your child prefer to play alone or with others? □ Alone □ With others
What are your child's interests, hobbies, and recreational activities?

_____

Academic and Work History

Current grade: _____ Current school: _____

Primary teacher (if applicable): _____School counselor: _____
Please list past schools: _____
_____
_____

Has your child had any academic problems or skipped a grade? □ Yes □ No
If yes, please describe:

_____
_____

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How is your child currently performing in the following areas? (i.e. A, B, C, D or F)

_____ Math _____ Science _____ Reading _____ Writing _____ English _____ Social Science
_____ History _____ Physical Education

What behavioral problems has your child had in school? (Please check all that apply)
□ None Please describe: _____
□ Fighting Please describe: _____
□ Uncooperative Please describe: _____
□ Other Please describe: _____

Is your child currently employed? □ Yes □ No
If yes, where and how many hours? _____

Past employment: _____

Medical History

Name of child's current physician: _____Phone Number: _____
Date if last examination or physical: _____/_____/_____
Has your child ever been hospitalized? □ Yes □ No
If yes, please describe all occurrences and reasons:
_____
_____

Does your child have any of the following medical conditions?

_____ AIDS/HIV	_____ Anemia	_____ Asthma	_____ Allergies
_____ Brain Injuries	_____ Cancer	_____ Colic	_____ Dizziness
_____ Ear Infections	_____ Headaches	_____ Head Injuries	_____ Hearing problems
_____ High Fever	_____ Influenza	_____ Pneumonia	_____ Seizures
_____ Skin problems	_____ Tuberculosis	_____ Vision	_____ Other

Please briefly describe and checked medical conditions:
_____
_____
_____
List all medications taking for the checked conditions:
_____
_____
_____

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List any diets or exercise programs:

_____

_____

_____

List any other medical problems and associated medications:

_____

_____

_____

Legal History

Has your child ever had any legal problems? □ Yes □ No

If yes, please describe when it occurred and what it was over:

_____

_____

Does your child have a probation officer? □ Yes □ No

If yes, please list name and phone number: _____ Phone: _____

Substance Use

History: □ Yes □ No Current: □ Yes □ No

Substance: _____ Frequency: _____ Amount: _____

Substance: _____ Frequency: _____ Amount: _____

Substance: _____ Frequency: _____ Amount: _____

Longest period of sobriety: _____ Length of use: _____

Prior treatment:

_____

_____

To the best of my knowledge the information provided is accurate and true.

I agree to counseling treatment for my child at Cornerstone Clinic, Medical and Counseling Center.

Signature is required of BOTH custodial parents or legal guardian(s).

_____ _____

Signature Date

_____ _____

Signature Date

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Child & Adolescent Intake Questionnaire

Rate the items in which your child is currently having problems.
Circle the number that best indicates the existence or severity of the problem.
0 = none 1= minor 2 = moderate 3 = significant 4 = serious

Circle the word or words that best define each statement:

Anxiety (worry) (fear) (panic) (phobia)	0	1	2	3	4
Feelings of (depression) (sadness)	0	1	2	3	4
Thoughts (death) (suicide)	0	1	2	3	4
Sleep disturbances	0	1	2	3	4
Mood swings	0	1	2	3	4
Grief over (death of loved one) (major loss)	0	1	2	3	4
Issues related to (pregnancy) (abortion)	0	1	2	3	4
Sexual abuse (incest) (rape)	0	1	2	3	4
Parental (alcohol) (drug) problems	0	1	2	3	4
Problems with (siblings) (parents) (friends)	0	1	2	3	4
Problems with (work) (school) (legal)	0	1	2	3	4
Sexual (concerns) (problems)	0	1	2	3	4
Problems with (alcohol) (drugs) (smoking)	0	1	2	3	4
Feeling of (hopelessness) (helplessness) (despair)	0	1	2	3	4
Memory (forgetfulness) (changes)	0	1	2	3	4

Reports being watched	□ Yes	□ No
Reports hearing voices when no one is around	□ Yes	□ No
Reports faces appearing distorted	□ Yes	□ No
Reports colors appear to be bright or faded	□ Yes	□ No
Has the child ever attempted suicide	□ Yes	□ No

State in your own words what has brought your child to counseling:

_____

_____

_____

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Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score

While you were growing up, during the first 18 years of life:

1. Did a parent or other adult in the household **often…**
   Swear at you, insult you, put you down, or humiliate you?
   Or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes, enter 1 _____
2. Did a parent or other adult in the household **often…**
   Push, grab, slap, or throw something at you?
   Or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes, enter 1 _____
3. Did an adult or person at least 5 years older that you **ever…**
   Touch or fondle you or have you touch their body in a sexual way?
   Or
   Try to actually have oral, anal, or vaginal sex with you?
   Yes No If yes, enter 1 _____
4. Did you **often** feel that…
   No one in our family loved you or thought you were important or special?
   Or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes, enter 1 _____
5. Did you **often** feel that…
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   Or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes, enter 1 _____
6. Were your parents ever separated or divorced?
   Yes No If yes, enter 1 _____
7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   Or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   Or
   Ever repeatedly hit or at least a few minutes or threatened with a gun or knife?
   Yes No If yes, enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes, enter 1 _____
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes, enter 1 _____
10. Did a household member go to prison?
    Yes No If yes, enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

CORNERSTONE HEALTH

Consent to Treat a Minor

I understand that my son/daughter is receiving individual therapy at Cornerstone Health Counseling. I understand completely that the counselor is providing mental health treatment and is not acting as an evaluator or investigator of any kind.

I further understand that Cornerstone Health Counseling is not conducting a custody or visitations disputes, as I understand that would not be in the best interests of my child's treatment relationship with the counselor and would be counter-productive to the therapeutic process. I agree to not involve the counselor in court proceedings regarding treatment of my child now or in the future nor will he/she be asked to share my child's records regarding any such proceedings.

A SIGNATURE IS REQUIRED OF BOTH CUSTODIAL PARENTS OR LEGAL GUARDIAN

Child's Name: _____DOB: _____

Mother or Parent Guardian: _____ Date: _____

Father or Parent Guardian: _____ Date: _____

CORNERSTONE HEALTH

Financial Policy

Agreement for Payment for Services

Any insurance co-payments are due at the time of service. At your initial appointment you must provide your insurance card and identification.

Co-Pay: A pre-set amount that is your responsibility at each visit. This is a flat rate that is subject to change each time your policy is renewed.

Co-Insurance: A percentage of your visit which will be calculated on the amount your insurance discount allows for the type of service you are receiving. This amount may change from visit to visit depending on the complexity of your appointment and or additional services rendered during your appointment.

Statements: Each month you will receive a statement for your portion of any bill that is due within 30 days of receipt. You will be asked at your next appointment for any outstanding balance payment in full unless prior arrangements for payments have been made.

Outstanding Balances: **If your responsibility balance becomes greater than $250.00 at any time, Cornerstone Health Counseling requires payment agreements be made and followed in order to continue treatment. If at any time it is determined that good faith payments are not being made on any account. Cornerstone Health Counseling reserves the right to deny services until accounts are paid in full. Not fulfilling financial obligations to Cornerstone Health Counseling is** also grounds for discharge from the practice. If there is a credit balance on your account at any time and you are still receiving treatment, please note that the credit will be applied to future fees incurred. Overpayments on accounts will be refunded if no longer receiving services within a period of six months.

While Cornerstone Health Counseling staff strives to make sure all your financial obligation for services are clearly explained to you prior to your visit, **it is your responsibility to understand what your insurance covers and does not.** Cornerstone Health Counseling recommends you contact your insurance company by calling the number listed on your insurance card and inquire about your mental health benefits allowing you to be aware of any costs that may become your responsibility as part of your treatment with Cornerstone Health Counseling.

I also understand and acknowledge that I am personally responsible for paying Cornerstone Health Counseling for services that my health insurer will not cover due to non-payment of my health insurance premiums.

_____ _____

Printed Name of Client **Date**

_____

Signature of Client or Authorized Representative

HIPAA – Notice of Privacy Policies

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us, and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the timeframe, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

CORNERSTONE HEALTH

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information, we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail, we will follow the same guidelines.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information are as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for nonemancipated minors must be requested by their custodial parents or legal guardians.

You have the right to cancel a release of information by providing us with written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

Complaints

If you have any complaints or questions regarding these procedures, please contact our Practice Manager. We will get back to you in a timely manner.

I have read and understand the Notice of Privacy Policies. I also acknowledge that if I desire a written copy of this notice, that I may obtain it at any time by requesting it from the Clinic.

_____ _____

Signature of Client or Authorized Representative **Date**

CORNERSTONE HEALTH

Client Election for Self-Pay for Services

□ **No insurance** □ **I do not wish for my insurance to be billed.** □ **I will be billing my insurance.**

If you will not be billing insurance, please Initial below and sign at the bottom.

I, _____ the undersigned patient, acknowledge that I understand and agree that:

_____ Cornerstone Health Counseling may be a participating provider with _____.
Name of Insurance

_____The health plan under which I am covered may or may not include benefits for some or all the services provided by Cornerstone Health Counseling.

_____Despite the above, I do not wish Cornerstone Health Counseling to submit a claim to my insurance for services provided to me by Cornerstone Health Counseling.

_____Until such time as I may otherwise advise Cornerstone Health Counseling in writing, I elect to pay for all services I receive from Cornerstone Health Counseling.

_____By election to self-pay for services, any payments I make to Cornerstone Health Counseling will not be credited toward satisfying any deductible I may be subject to under my health insurance plan.

_____I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about this form. Any questions I may have had about this form have been answered to my satisfaction.

_____I have freely chosen to self-pay for services after having asked Cornerstone Health Counseling about payment options and having carefully considered those options.

_____ _____
Signature of Client or Authorized Representative **Date**

_____
Printed Name of Client

CORNERSTONE HEALTH

Informed Consent for Services by Student Interns

I understand that Cornerstone Health Counseling undergraduate and advanced graduate students from the mental health profession are not yet licensed in Alaska.

I understand that all students are supervised by a minimum of a Master's prepared Clinical Supervisor. Supervision includes face-to-face supervision sessions reviewing and co-signing treatment plans, progress notes, and signing off on all other documents that go into your clinical record.

I understand that I have the right to know the name of the Student Intern, their supervisor and how to contact her or him, the front office will provide this information upon request.

Your signature below indicates that:

1. You have read the information in this document and consent to services provided by Cornerstone Health Counseling Student Interns.

2. Your protected health information (PHI) is strictly confidential and is protected by Federal and State regulations (42CFR Part 2, 45 CFR 160, 162, and 7 AAC 71.215)

_____ _____

Printed Name of Client **Date**

_____

Signature of Client or Authorized Representative

CORNERSTONE HEALTH

Extended Confidentiality

It has come to our attention that there may be individuals who you (our client) may allow to make or cancel an appointment for you.

Ethics surrounding confidentiality state that without your permission, we can neither verify nor deny you are a client of Cornerstone Health Counseling. This standard holds true even if you are seen as part of a couple; we would not give your parent/spouse/partner/friend any information regarding your treatment at Cornerstone Health Counseling, nor allow them to make, verify, or cancel an appointment without your permission.

I give the following individuals access to (please initial all that apply):

_____ **Billing Information**

_____ **Client Records**

_____ **Appointment Information**

_____ _____
Client Name **Date**

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

This authorization will stay in effect until you inform Cornerstone Health Counseling otherwise.

CORNERSTONE HEALTH

Consent for Telehealth Services

Telehealth or Telemental health is the practice of delivering clinical health care services to counseling clients using interactive video and/or audio communications.

The same laws that apply in face-to-face counseling also apply in telemental health. In other words, everything in the telemental health session remains confidential unless:

- The client/counselor learns of child, elder, or handicapped persons abuse.
- In the case of threatened homicide or suicide.
- Ordered by a judge or court to release records.

Telehealth services are provided for the convenience of our clients. Telehealth service is not required and is only used upon mutual agreement between provider and client. Telehealth services are subject to the following:

1. Telehealth services are not the same as an in-person visit, as you will not be in the same room as your provider. If your provider determines that telehealth is not adequate for a particular issue, the provider may choose to terminate and request an in-person session.
2. You have the right to withdraw consent at any time without affecting your right to future care or services.
3. Cornerstone Health Counseling will utilize technology that is HIPAA compliant as far as it is able. As the client, you have the responsibility to secure a confidential setting for yourself.
4. You understand that there may be risks, benefits and consequences associated with telemental health: disruption of transmission by technology failures, interruption, breaches of confidentiality by unauthorized persons and/or limited ability to respond to emergencies.
5. There will be no recording of any of the online sessions by either party. Written records will not be disclosed to anyone without written authorization unless required by law.
6. Services will be billed through our billing company like face-to-face visits. If for some reason your insurance company will not pay for telemental health services, you will be responsible for your bill. Before you are scheduled for a telemental health visit, please make these arrangements with our front desk at (907) 522-7080.

You understand that your therapist may need to contact your emergency contact and/or appropriate authorities in case of an emergency.

CORNERSTONE HEALTH

Consent for Telehealth Services

Emergency Protocols

Your counselor needs to know your location in case of an emergency. You agree to inform us of where you are at the beginning of each session. We also need to know who we may contact on your behalf in case of a life-threatening emergency only.

Address of My Location During Sessions:

_____ **City**: _____ **State:** _____ **Zip:** _____

Emergency Contact Person

Name: _____ Phone Number: _____

Address: _____

Relationship to Client: _____

I have read the information provided above and will discuss it with my therapist. I understand that the information contained in this form and my questions have been answered satisfactorily.

_____ _____

Signature of Client or Authorized Representative **Date**