



Registration Form

Date: _____

Name: _____

I certify that I am the parent or legal custodial guardian of: _____
and I grant permission for my child to participate in Artplay. I understand that it is a therapeutic program for children and a description of the program has been provided.

Signature: _____

Current Address: _____

Phone Numbers: (home) _____ (cell) _____

Email: _____

Child's Full Name: _____ Male Female

Date of Birth: _____ Age: _____

Name of School Child Attends: _____ Grade: _____

Name(s) of other Mental Health Professionals Your Child has Seen: _____

Current Medications Child is Taking: _____

Describe Your Current Concerns: _____

Check all that apply:

- ACCIDENT PRONE DEMANDING LYING TANTRUMS DESTRUCTIVE HYPERACTIVITY
 REFUSES EYE CONTACT SELF-PARENTING STOMACH ACHES TEARFUL WHINING
 SLEEP PROBLEMS WITHDRAWN FEARFUL TESTS LIMITS HEADACHES

Please fax this completed form to 602-476-2103 or bring it with you to the first session.

Artplay, LLC • www.artplayhealing.com

Confidentiality Form

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient (your child) and a therapist. In most situations, Artplay can only release information about your child to others if you sign a written authorization form that meets legal requirements imposed by the Health Information Protection and Portability Act (HIPPA). There are other situations that require that you provide written consent in advance. Your signature on this agreement provides consent for those activities, as follows:

- Artplay may consult with mental health professionals about your child's behavior and emotional needs. These health professionals are also legally bound to keep the information confidential.
- If a child threatens to harm themselves, Artplay will seek family members who can provide protection.
- If a child threatens to harm someone else, Artplay is obligated to report to authorities.
- If a child reports maltreatment, Artplay is obligated to report these concerns to Child Protective Services.

Your signature below indicates that you have read and understand the limits of confidentiality statement:

Print Child's Name: _____

Print Parent/Guardian Name: _____

Parent Signature: _____

Date: _____

Consent for Release of Information

(only if deemed necessary)

Client Name: _____

Date of Birth: _____

I, _____ hereby consent and authorize Artplay, LLC to release specified information concerning the above named individual to:

Name _____

Phone: _____

Address: _____

For the purpose of: _____

This informed consent for the release of information will automatically expire without further action ninety days after the date on which it was signed. I hereby release Artplay, LLC from all legal responsibility that may arise from the above requested information. This authorization is fully understood and it is made voluntarily and with informed consent on my part.

Signature: _____

Date: _____

Please fax this completed form to 602-476-2103 or bring it with you to the first session.

Artplay, LLC • www.artplayhealing.com