

Inspirations For Youth and Families Facesheet / Admissions Profile

1. Medical Records		2. Client's Name (First, Middle Initial, Last)		3. Admit Date		4. Discharge Date	
5. Client's Current Address (Include City, State & Zip Code)				6. Telephone #			
				()			
				7. Admitting Diagnostic Impression			
8. Sex	9. Race	10. Marital Status	11. Age	12. Birthday	13. SS#		
14. Emergency Contact		Relationship	Address (include city, state & zip code			Telephone #	
15. Guarantor's Name		Relationship	Address (include city, state & zip code			Telephone #	
16. Guarantor's Date of Birth				17. Guarantor's SS#			
18. Guarantor's Employer			Address (include city, state & zip code			Telephone #	
19. Name of Current School				Telephone #		Current Grade	
20. Primary Insurance Carrier			Policy I.D. #		Group I.D. #		
21. Secondary Insurance Carrier			Policy I.D. #		Group I.D. #		
22. Referral Source (Full Name and Licensure of Referring Health Care Professional & Agency / Facility Affiliated With)							
23. Attending Physicians:				24. Allergies:			
Notes:							

Clinician Signature: _____

Date: _____

PATIENT QUESTIONNAIRE

1. Why did you come to treatment today?

2. What are your drugs of choice?
 - a. First use?
 - b. Last use?
 - c. Amounts used?

3. Any previous treatment?
 - a. Inpatient
 - b. Outpatient
 - c. Therapist
 - d. Doctor

4. Have you ever attended an AA or NA meeting? If so when, which and where?

5. Does any family member have a drug or alcohol problem? If so, who?

6. What grade are you in?
 - a. How are your grades at this time?

7. Are you employed?
 - a. By whom?
 - b. Is your job threatened?

8. Any current legal issues?

9. Have you been prescribed any medications?
 - a. Do you take them as prescribed?

10. How is your sleep?
 - a. How is your appetite?

Signature: _____

Date: _____

24 SW 10TH STREET ♦ FORT LAUDERDALE ♦ FLORIDA 33315
PHONE: 954-376-4783 ♦ FAX: 954-527-8857

Inspirations Academy
At
Inspirations For Youth and Families

Student Name: _____ Social Security # _____
DOB: _____ Parent(s): _____

Home Address: _____

Mother Work Phone: _____ Cell: _____

Father Work Phone: _____ Cell: _____

Email Addresses: _____

Current High School: _____

Current High School Address: _____

Name of Principal: _____

Name of Guidance Counselor: _____

Current Grade Level: _____

Academic Courses: _____

List of Class Levels (AP, Honors, IB, IEP): _____



RELEASE FOR EDUCATIONAL INFORMATION

I _____ hereby authorize Inspirations for Youth and Families, LLC, Educational Advisor to discuss all academic/educational records for my son/daughter _____.

Parent/Guardian Signature: _____

Date: _____

24 SW 10th Street
Ph: 954-376-4783

Ft. Lauderdale, Florida 33315
Fax: 954-527-8857

Dania Rexall Pharmacy- Institutional Pharmacy
Credit Card Authorization Form

FACILITY NAME: _____

PATIENT NAME: _____ **DATE:** _____

PRESCRIPTION INSURANCE CARRIER: _____

RX INS. PHONE #: _____ **PERSON CODE:** _____

POLICY ID#: _____ **GROUP ID#:** _____

CREDIT CARD HOLDERS NAME*: _____

* AS APPEARS ON CREDIT CARD

BILLING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

CREDIT CARD TYPE: (CIRCLE ONE)

AMERICAN EXPRESS **VISA** **MASTERCARD**

CREDIT CARD NUMBER: _____

EXP: _____ **SEC. CODE:** _____

I, (Credit Card Holder) _____, am the responsible party for (Patient) _____. I authorize Dania Rexall Pharmacy to apply any and all charges for the above mentioned patient to my credit card account, noted above. The charges may include, but are not limited to the following: co-payments, deductibles, over-the-counter items, medication not covered by insurance, medical equipment and supplies, or any other cash service provided by Dania Rexall Pharmacy. I understand I will receive a monthly statement listing all charges to my billing address. If patient account reaches sixty (60) days past due, patient medication will be held until account is paid. We take into account financial hardships, if you or the responsible parties are unable to render payment in full, please contact our office to discuss payment options.

Signature of Card Holder Print Name Date

Signature of Technician Print Name Date

Inspirations for Youth and Families, LLC

Orientation to the Program

Date: _____

Name: _____

DOB: _____

MR#: _____

_____ Description of Services Provided

_____ Program Fees

_____ Client Rights

_____ Limits of Confidentiality HIPPA

_____ Therapy Agreement

_____ Consent Agreement

_____ Client Rules and Standard of Conduct

_____ Authorization to Release Information

_____ Information on Infection Control Policy

_____ Grievance Procedure

Signature of Client: _____

Signature of Parent or Guardian: _____

Witness: _____

Inspirations for Youth and Families, LLC Client Rights

Date: _____

Name: _____

DOB: _____

MR#: _____

1. You have the right to participate in company programs regardless of race, national origin, religion, color, age, sex, marital status, handicap, disability of any other characteristic protected by law.
2. You have the right to be treated with dignity and courtesy. You are entitled to care that is considerate and respectful of your personal values and beliefs. It is your responsibility to respect the rights of theirs and to be considerate of them.
3. You have the right and the obligation to participate in your individualized treatment plan, which shall be based upon your strengths, needs and limitations.
4. You have the right to have a copy of your treatment plan, and to review your treatment plan monthly.
5. You have the right to be protected from abuse, neglect and exploitation. The Abuse Hotline is 1-800-96-ABUSE.
6. You are responsible for your own possessions and valuables.
7. You have the right to privacy and confidentiality, as do all other individuals, when participation in this program, yet understand that group decisions and confidentiality is upheld by group members, relinquishing this company from responsibility for group confidentiality by its members.
8. You have the right to a safe and secure environment during your attendance in this program.

I acknowledge that I have had an opportunity to discuss these rights and responsibilities and I have had all my questions answered.

Signature of Client: _____

Signature of Parent or Guardian: _____

Witness: _____

Inspirations for Youth and Families, LLC

Therapy Agreement

Date: _____

Name: _____

DOB: _____

MR#: _____

I hereby grant my permission for any therapy that may be deemed pertinent by the staff of **Inspirations for Youth and Families, LLC**. I understand that my counseling sessions are strictly confidential. However, I understand that the therapist may be requested to honor court subpoenas.

I authorize therapist at **Inspirations for Youth and Families** to use information obtained in the counseling sessions for the purpose of evaluation by a supervisor or consultation with other clinical colleagues, who are bound to honor confidentiality.

I understand that the therapist have an obligation to report knowledge of or instance of suspected child or elder abuse or neglects as mandated by Florida Statue # 415.504.

I understand that a session fee will be charged and must be paid in the event I do not appear for an appointment.

Signature of Client: _____

Signature of Parent or Guardian: _____

Witness: _____

Inspirations for Youth and Families, LLC

Consent Agreement

Date: _____

Name: _____

DOB: _____

MR#: _____

I hereby authorize Inspiration's professional staff to assess, evaluate and administer treatment. I certify that I have been informed of the nature and purpose of this treatment. I have been informed that this consent can be revoked orally or in writing, prior to or during the treatment period.

2. I understand that this is a voluntary program. However, individuals may be court ordered to attend.
3. I have been informed and understand that my medical records are confidential and will not be disclosed unless I give written authorization for release. I understand that exceptions to this include (1) a Federal or State Court Order for my medical record, (2) a life-threatening emergency and/or (3) any governmental agency having jurisdiction over this facility.
4. I understand that my treatment includes group therapy. I also understand that topics shared by myself and other patients are confidential. Information discussed in these sessions is confidential and can only be released in accordance with Federal and State statutes on confidentiality.
5. I understand that my treatment may include individual therapy. Information discussed in these sessions can only be released in accordance with Federal and State statutes on confidentiality.

Signature of Client: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Witness: _____ Date: _____

Inspirations for Youth and Families, LLC

Client Random Drug / Alcohol Screen

Date: _____

Name: _____

DOB: _____

MR#: _____

I, _____, understand that I will be subject to periodic drug and/or alcohol screens. This test is done to verify my abstinence from any substances.

Signature of Client: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Witness: _____ Date: _____

Inspirations for Youth and Families, LLC

Acknowledgement of Receipt of HIPPA

Notice of Privacy Practices

I hereby acknowledge receipt of this company's Notice of Privacy Practices.

I understand that if I have any questions, I may request a meeting with this company's Privacy Officer for further explanation.

Name of Client: _____ Date: _____

Signature of Client: _____

Signature of Parent or Guardian: _____

Witness: _____

FLORIDA LOCAL ADVOCACY COUNCIL

ADM PLANNING COUNCIL

954-746-2055

SUBSTANCE ABUSE AND NEGLECT HOTLINE

1-800-96-ABUSE

DISTRICT 17 SUBSTANCE ABUSE AND MENTAL

HEALTH OFFICE

954-762-3700

I HAVE RECEIVED A COPY OF THESE LOCAL
RESOURCES.

Signature of Client:

Witness:

Residential Structured Living / House Rules

1. Remain on facility property.
2. Attend and participate in all house activities
3. Attend daily AA meetings
4. Adhere to curfew
5. Participate in random urine drug screens
6. Keep your room and apartment clean. Follow chore list.
7. NO VISITORS at the residence. (Visitation is at the treatment center with prior permission from administration. You must also complete a request form during the week for weekend visitation)
8. You must get permission prior to entering tenant's apartments
9. Opposite genders are not allowed to enter or visit apartments
10. No smoking
11. Violence or threats of violence is grounds for immediate dismissal
12. Do not borrow or lend money, clothes, or any materials items
13. Food is not permitted in bedrooms or in the transportation vans
14. No pornography
15. No cellular telephones. Headphones remain at residence and are not allowed in the treatment center
16. Weight gaining products, dieting products, energy liquids and other body altering products are not allowed
17. All requests for appointments or special needs must be requested prior to the weekend with a request form authorized by the primary therapist

Confidentiality is to be upheld at all times

All concerns need to be directed to OUR STAFF and OUR ADMINISTRATION

Failure to adhere to these rules may result in a discharge from our treatment program

Client Signature: _____

Date _____

Witness: _____

Date _____

24 SW 10th Street
Fort Lauderdale, Florida 33315
PH: 954-376-4783 FAX: 954-765-0787

INSPIRATIONS FOR YOUTH AND FAMILIES, LLC
GRIEVANCE PROCEDURE

Date:

Client Name:

MR#:

I, _____, understand that I may complete a Grievance form, in which I have the right to document any concerns or objections during my time here in Inspirations For Youth And Families, LLC. I also understand that the company will attempt to resolve any reasonable requests in a timely manner and/or respond to my grievance verbally or written within 72 hours.

Client Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____

Witness: _____ Date: _____

INSPIRATIONS

FOR YOUTH AND FAMILIES, LLC

VISITATION

Date:

Name:

Date of Birth:

MR#:

Visitation with clients will only be permitted after successful family sessions are done. Family sessions will be conducted during business hours only, Monday to Friday, 9-5 (unless extenuating circumstances prevail). Family sessions will be scheduled through clinical staff in co-operation with families. If family sessions are not done **no** visitation will be allowed. Length and time of visits will depend on behaviors of client when scheduled.

X _____
Parent Signature

Date

X _____
Client Signature

Date

X _____
Witness

Date

24 SW 10TH STREET ♦ FORT LAUDERDALE ♦ FLORIDA 33315
PHONE: 954-376-4783 ♦ FAX: 954-745-8309
WWW.INSPIRATIONSYOUTH.COM

INSPIRATIONS

FOR YOUTH AND FAMILIES, LLC

DEPARTURES / ADMISSIONS

Date:

Name:

Date of Birth:

MR#:

Departures of client will be allowed only during business hours 9 – 5, Monday through Friday. This is to allow time to make arrangements for clients to leave in an appropriate manner (i.e. see nurse, discharge planning and medication issues). Arrangements for departures will be coordinated in co-operation with clinical staff and families.

Admissions will be done during business hours Monday to Friday 9-5 only, unless extenuating circumstances prevail and other arrangements have to be made.

X _____
Parent Signature

Date

X _____
Client Signature

Date

X _____
Witness

Date

24 SW 10TH STREET ♦ FORT LAUDERDALE ♦ FLORIDA 33315
PHONE: 954-376-4783 ♦ FAX: 954-745-8309
WWW.INSPIRATIONSYOUTH.COM

ACTIVITIES RELEASE AND WAIVER OF LIABILITY

Notice: This form contains a release and waiver of liability and when signed is a contract between the undersigned participant and INSPIRATIONS FOR YOUTH AND FAMILIES LLC with legal consequences. Please read this Agreement consisting of three (3) pages in its entirety carefully before signing your name at the bottom of each page and before signing the last page, page 3. This form must be signed in the presence of two (2) witnesses who should sign as witness.

CLIENT'S INFORMATION

Date of Execution of Release and Waiver of Liability: _____

The undersigned agrees that this Release and Waiver of Liability form agreement is valid from the date of execution through the date of discharge.

Activities: Participation in voluntary sports activities or voluntary physical activities such as volleyball, aerobics, and any other similar types of voluntary sports or physical activities which may not be specifically identified herein.

Client's Full Name (Printed or Typed) _____

Parent/Guardian's Full Name (if client has been determined legally incompetent or is under age 13) (Printed or Typed) _____

Parent/Guardian's Phone Number _____

Name and Telephone Number of Immediate Contact Person for Client _____

Acknowledgments and Representations by Client:

The undersigned client _____ is currently a patient at a residential/outpatient facility operated by INSPIRATIONS FOR YOUTH AND FAMILIES LLC. The undersigned has voluntarily consented to participate in voluntary sports activities or voluntary physical activities such as volleyball, aerobics, and other such type of voluntary sports or physical activities, which may not be specifically identified herein while being a client at such facility.

Client's Signature _____

(or parent guardian of client) above

INSPIRATIONS

FOR YOUTH AND FAMILIES, LLC

DISCLAIMER HOLD HARMLESS

I (we) _____ understand Inspirations For Youth and Families is NOT a locked facility and is licensed as a Day/Night Facility with community housing, licensed by the Division of Children & Families, in the state of Florida. By signing this document, I (we) agree to hold harmless any negative consequences including physical, emotional, legal and otherwise, that may occur in the event my (our) child leaves treatment against medical advise and without written permission of the clinical staff of Inspirations For Youth and Families, LLC and/or their medical director.

Date

Parent Guardian

Staff

24 SW 10TH STREET ♦ FORT LAUDERDALE ♦ FLORIDA 33315
PHONE: 954-376-4783 ♦ FAX: 954-745-8309

INSPIRATIONS FOR YOUTH AND FAMILIES, LLC.

DURABLE POWER OF ATTORNEY

KNOWN ALL MEN BY THESE PRESENTS, this power of attorney is intended to constitute a Durable Power of Attorney under Chapter 709 of the Florida Statutes, THAT I _____ (name of CLIENT) AND OR GUARDIAN OF THE CLIENT (the "PRINCIPAL"), having an address at: _____

Hereby makes, constitute, and appoint each and all of:

INSPIRATIONS FOR YOUTH AND FAMILIES, LLC

My true and lawful attorney-in-fact TO ACT SEVERALLY in my name, place and stead to do and perform all and every act and thing whatsoever requisite and necessary in any way which I could or might do, if personally present, with the respect to the care, housing, medical, clinical, and psychological care, addiction treatment, and concern for my child: _____, as well as obtaining payment and/or reimbursement for medical, chemical dependency treatment and other health care services rendered to the Principal by INSPIRATIONS FOR YOUTH AND FAMILIES, LLC, whose address is 24 Southwest 10th Street Fort Lauderdale, Florida 33315 or any of its affiliates, including, but not limited to obtaining insurance, making of claims against insurers, or other third-party payers. Instituting and prosecuting and/or defending litigation, arbitration and/or other dispute resolution proceedings, compromise and/or statement or claims and/or disputes, obtaining and/or releasing records, reports and statements, including but not limited to any and all medical reports and records from prior treatment providers, subject to complying with federal confidentiality rules under 42 CFR Part 2, as well as all other acts which may be helpful and appropriate to the accomplishment of such purposes, for the ultimate objective of collection for such services. Such additional acts shall include, without limitation, endorsing any draft, check or other negotiable instrument representing insurance or other third party

benefits received by or on behalf of the Principal, the filing of all documents and forms which may be necessary or appropriate to maintain, continue or extend health care insurance, including but not limited to continuation of coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (“Cobra”), 29 U.S.C. Section 1161 Etseq.

Each of my said attorneys shall have full and unqualified authority to my attorney(s)-in fact to delegate any or all of the foregoing powers to any person or persons whom my attorney(s)-in-fact shall select, to the maximum extent from time not forbidden by law.

Parent or Guardian _____ Date: _____

Witness _____ Date: _____

DAY TREATMENT MEDICAL / HEALTH HISTORY

CLIENTS NAME: _____ CLIENT# _____

DATE OF BIRTH: _____ AGE: _____ DATE: _____

HEIGHT: _____ WEIGHT: _____ WEIGHT LAST: _____

DRUG ALLERGIES: _____

DATE OF LAST PHYSICAL EXAM: _____

CURRENT MEDICATIONS: _____

CURRENT PHYSICAL COMPLAINTS / DISEASES: (CHECK IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING PROBLEM):

- | | |
|--|--|
| <input type="checkbox"/> Shakes / Tremors | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Irregular Menstrual Cycle | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty Walking |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Ear of Hearing Problems |
| <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Anemia /Blood Disorders | <input type="checkbox"/> Weight Problems |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Eye or Sight Problems |
| <input type="checkbox"/> Bleeding Easily | <input type="checkbox"/> Others |

WOMEN ONLY

Pregnant: yes ___ no ___

Planning Pregnancy: yes ___ no ___

HABITS

Smoke: yes ___ no ___ **Packs Daily:** ___ **How Long:** ___ **When Stopped:** ___

Coffee: yes ___ no ___ **Cups Daily:** ___

Exercise Routine: _____



Sleep Pattern: _____

Hospitalizations of Surgeries: _____

(Reasons and Dates) _____

Do you have any past medical problems, which you feel would be significant for THE COVE to be aware of while you are under our care? __ yes __ no

If yes, elaborate: _____

Are you currently under the care of a physician for these medical problems? Yes ____ no ____

If yes, elaborate: _____

If yes, name and phone of number of physician, and date of last visit:

Family / Medical History:

Mother: _____ Father: _____

Siblings: _____

Any other Health or Medical problems we should know about related to your

Family? _____

Do you have any concerns about your health? ____ yes ____ no

If yes, please explain: _____

Do you feel you have a health situation that may cause you problems during your treatment? ____ yes ____ no

If yes, please explain _____

All the above information is true and completed to the best of my ability.

Client Signature: _____

Client referred for medical review: ____ yes ____ no

REVIEWED BY:

Staff Signature: _____ Date _____

REVIEWED BY MEDICAL STAFF;

Physician's Signature: _____ Date _____

Physician Print Name: _____

AUTHORIZATION FOR RELEASE / REQUEST OF INFORMATION

Client Name: _____ Client # _____

Authorization for: _____ RELEASE OF INFORMATION _____ REQUEST FOR INFORMATION

Re: _____ DOB: _____

Date(s) of Treatment: _____

I hereby authorize _____ to release copies of the following confidential information which may include alcohol and substance abuse information which may be protected under Federal Regulations in Code 42, part 2, and/or abstract information, which includes medical, psychiatric and/or psychological, HIV Antibody testing information to:

NAME: _____

and/or its representative or entity solely for the purpose of _____
(Under the Mental Health Code, release of mental health records must be germane to the purpose and need for disclosure)

I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING:

- | | |
|--|---|
| _____ Medical History & Physical Examination | _____ Admission/Evaluation Summary(ies) |
| _____ Progress Notes | _____ Psychological Evaluation |
| _____ Treatment Plans & Reviews | _____ Physician Orders |
| _____ Discharge Summary | _____ Discharge Treatment Summary |
| _____ Consultation Reports | _____ Laboratory & X-ray reports |
| _____ Other: <u>Copies as needed for treatment</u> | _____ Acknowledgement of Presence |
| _____ Entire Contents of my Client Chart | _____ Disclosure of Treatment Progress |

This authorization is valid for (120) days from date of signature or completion of treatment at the time of the final insurance billing, as the case may be, whichever is later. This authorization is subject to revocation at any time except to the extent the facility has already acted in reliance on it.

SIGNATURE OF CLIENT _____

DATE _____

WITNESS _____

DATE _____

PROHIBITION ON REDISCLOSURE

This information has be disclosed to your from records protected by Federal Law. Federal regulations prohibit making any further disclosure of this information unless expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by CFR 42, part 2. A general authorization for release of medical or other information is not sufficient for this purpose.

Released by _____

Date _____

**INSPIRATIONS
FOR YOUTH AND FAMILIES, LLC.**

**CHRISTIAN PROGRAM
CONSENT, HOLD HARMLESS, & RELEASE AND
WAIVER OF LIABILITY**

I (we), _____
(Print Name(s) of Parent(s) or Guardian(s))

give consent to allow _____ (Print Name of child(client) for whom you are Parent or Guardian,) to attend a non-denominational Church. I (we) give consent for my child(client) to receive a Bible and Christian literature. I (we) give consent for my child(client) to attend Christian based groups and Bible studies.

By signing this document, I (we) agree to hold harmless, Inspirations and any others involved, if any negative consequences and/or perceived negative consequences including physical, emotional, legal, and/or otherwise, that may occur while involved in the acts that consent is given. By signing this document, I (we) release and waive any liability that may arise while involved in the acts that consent is given. This release and waiver of liability, when signed is a contract between the undersigned and Inspirations for Youth and Families, LLC..

Client's Signature _____

Parent/Guardian Signature _____

Parent/Guardian Signature _____

Witness Printed Name _____

Witness Signature _____

KEEPING IN TOUCH

Date: _____

Inspirations for Youth and Families and its Affiliate Counseling Services would like to keep you informed about our future activities, such as workshops, seminars, spring, summer and winter camp programs by sending you periodic newsletters. (This is an option you can opt out at any time by unsubscribing from the service.)

I _____ authorize **Inspirations for Youth and Families and its Affiliate Counseling Services** to send me e-mails to the address (es) listed below.

E-mail Address (es):

Signature: _____

Parent's Address: _____

Best Phone Number to be Reached: _____

Patient's Name: _____

Teen Addiction Helpline: 1-888-757-6237
Info@InspirationsYouth.com
www.InspirationsYouth.com
www.InspirationsTeenRehab.com



MEDIA RELEASE FORM

As a parent of a teen in Inspirations for Youth and Families, I understand that my child and/or we as parents, may be photographed, videotaped or interviewed by the Inspirations media department or by national media. I understand that pictures and interviews may be used on Inspirations websites, Inspirations publications and electronic media.

You Must Mark a Choice in Both Section A and Section B

SECTION A

Please Check Choice #1 or Choice #2

(Please mark one choice or it may be assumed Choice #1 by default)

1. **I WILL** permit my teen (name below) to be photographed, filmed or interviewed by Inspirations media staff and/or outside news media for educational or promotional purposes.
2. **I WILL NOT** permit my teen (name below) to be photographed, filmed or interviewed by Inspirations media staff and/or outside news media for educational or promotional purposes.
- 3.

SECTION B

Please Check Choice #1 or Choice #2

(Please mark one choice or it may be assumed Choice #1 by default)

1. **I WILL** permit Inspirations for Youth and Families, LLC., to film , interview or photograph, me (us), parent (s), of the teen mentioned below, for educational or promotional purposes.
2. **I WILL NOT** permit Inspirations for Youth and Families, LLC., to film , interview or photograph, me (us), parent (s), of the teen mentioned below, for educational or promotional purposes.

_____ Teen's Name (Print)	_____ Teen's Signature	_____ Date
_____ Parent/Guardian Name (Print)	_____ Parent/Guardian Signature	_____ Date
_____ Parent/Guardian Name (Print)	_____ Parent/Guardian Signature	_____ Date

Teen Addiction Helpline: 1-888-757-6237
Info@InspirationsYouth.com
www.InspirationsYouth.com
www.InspirationsTeenRehab.com

