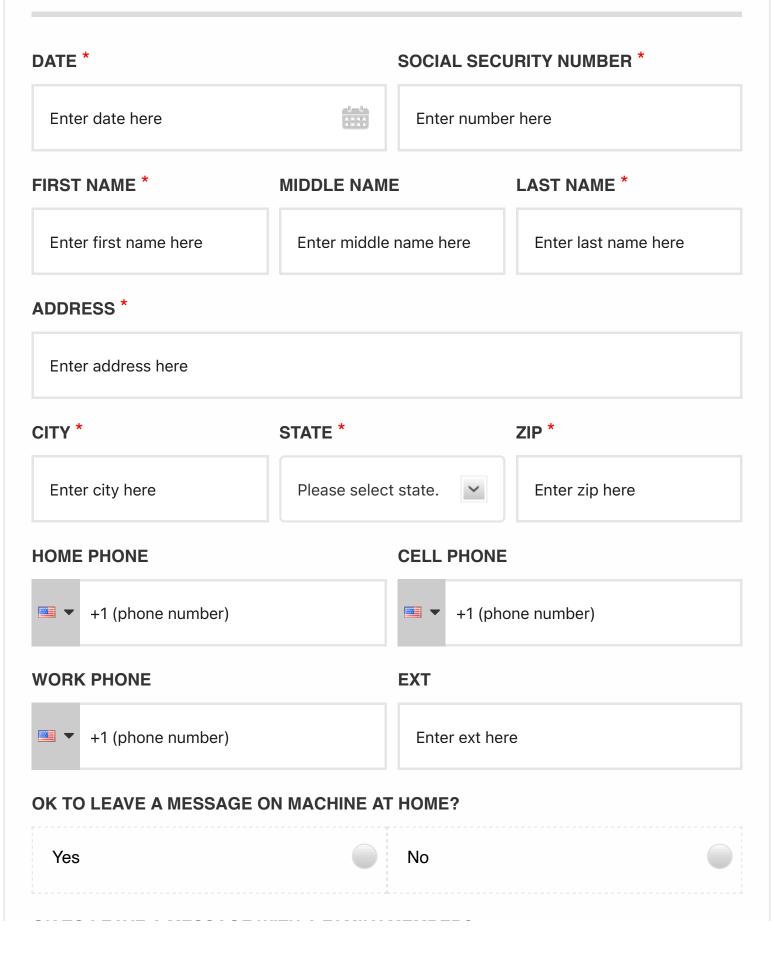
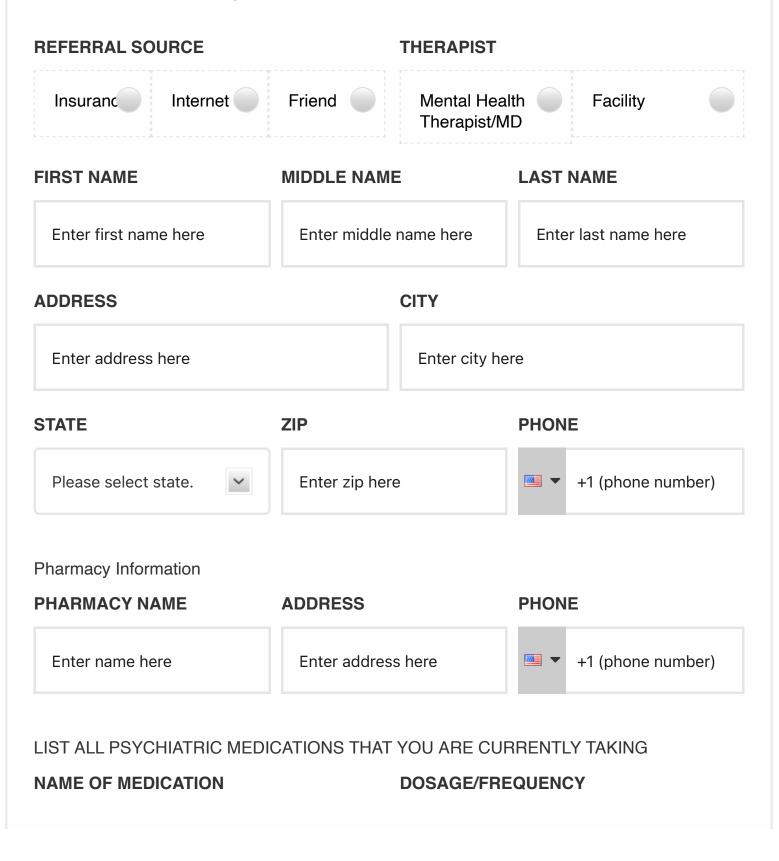
* REQUIRED INFORMATION



	No EMAIL)? No		
	No		
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Male Fema	ıle	Sing	Mar Divc d Sep te	
EMPLOYER OR SCHOOL (IF	APPLICABLE)			
Enter employer or school here				
EMPLOYMENT STATUS		OCCUPATION	J	
Enter status here	status here		Enter occupation here	
ADDRESS				
Enter address here				
Emergency Contact				
FIRST NAME	LAST NAME		RELATIONSHIP TO PATIENT	
Enter first name here	Enter last na	ame here	Enter relationship here	
ADDRESS		CITY		
Enter address here		Enter city he	ere	
STATE		ZIP		
Please select state.	~	Enter zip he	re	
HOME PHONE		CELL PHONE		

□ I authorize You First Health and Wellness Services LLC to contact the above-named person in case of an emergency.



Enter medication here	Enter dosage or frequency here
Enter medication here	Enter dosage or frequency here
Enter medication here	Enter dosage or frequency here
Enter medication here	Enter dosage or frequency here
Enter medication here	Enter dosage or frequency here

Patient-Provider Authorizations and Agreements.

Authorizations and Agreements with You First Health and Wellness Services LLC. Please read carefully and sign. The paragraphs below contain several agreements.

PATIENTS NAME	DATE
Enter name here	Enter date here

Financial Responsibility

□ I understand and agree that I am responsible for the fees to You First Health and Wellness Services LLC before services are rendered.

Primary Care Physician Contact Authorization

PRIMARY CARE PHYSICIAN'S NAME

Enter name here

ADDRESS

TELEPHONE NUMBER

FAX NUMBER

Enter number here

Enter number here

I, (Print Name)

Enter name here

hereby authorize You First Health and Wellness Services LLC

PLEASE CHECK ONE

To release any applicable mental health information to my primary care physician (PCP) above

To release any applicable substance abuse information to my PCP named above

To release only medical information to my PCP named above

Not to release any information to my PCP named above

I DO NOT HAVE A PCP AT THIS TIME

□ I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment.

PATIENT OR GUARDIAN NAME	DATE	
Enter name here	Enter date here	

Enter name here

(name of patient), agree and consent to participate in behavioral healthcare services offered and provided by You First Health and Wellness Services LLC, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) within scope of license, certification, and training of the behavioral health care provider directly supervising the services received by the patient.

PATIENT NAME

DATE

Enter name here

Enter date here

-1--1-

RELATIONSHIP TO PATIENT (IF APPLICABLE)

Enter relationship here