New Client Registration

Date_____

Name of client: _____

DOB: ____/____/____ **Age:** _____

Guardian Name: _____

Sibling/s: _____

Address: _____

City_____ **Zip**_____

Phone: ___-___-____ **Email:** _____

Emergency Contact:_____

Phone: _____

Allergies: _____**Type of reaction:** _____

Medical/Educational history

_____

_____

Musical interests

_____

How did you hear about Joyful Music services?

_____

Office use only

☐QB
☐CC

☐Assessment Date _____
☐Payment Received: Amount _____Cash _____ Check #_____ Credit Card Type_____

☐ Group Class _____
☐ Individual MT At home_____ At Center _____
☐ Assigned To Therapist_____
☐ Payment Plan_____

Joyful Music Therapy
407-489-1783
www.joyfulmusictherapy.com

Client Name: _____ Date of Birth: _____

CONSENT TO TREAT

I _____ consent for Joyful Music Therapy, LLC to provide _____ with Music Therapy Services. I consent to care and treatment falling under the practice guideline of the American Music Therapy (AMTA), and the state of Florida. I acknowledge that there is always a risk of injury with any therapy involving physical activities.

Parent/Guardian Signature Printed Name Date

An initial evaluation for music therapy services is $120/hour. Evaluations are a one-time fee with payment expected at the time of service. An initial evaluation will be needed for all clients starting therapy with our facility. Financial arrangements will be made prior to the time of evaluation.

Parent/Guardian Signature Printed Name Date

Individual Music Therapy Cancellation Policy

Clients will be billed at their scheduled session rate if a 12-hour cancellation notice is not given or in the event of a no-show.
The Board of Health considers the following signs to indicate communicable disease/illness: **vomiting, fever over 100 degrees, diarrhea, sore throat, rash/swelling, red, or running eyes**. Please be sure the client is symptom free for 24 hours before resuming therapy. Please note that if you come to therapy and he/she exhibits any of the above symptoms, it is at the therapist's discretion to send them home in order to protect themselves and our other clients from infectious illness.

Parent/Guardian Signature Printed Name Date

Required Credit Card

Your credit card will be charged for monthly payments not paid within 60 days of invoice. If you are unable to continue participation in music therapy services, you are required to notify the instructor and/or the office by the 15th of the month, or your credit card will be billed for the remainder of the month.

I authorize Joyful Music Therapy to maintain my credit/debit card on file. I understand that my card will be used if my account has become delinquent for more than 60 days. I further agree to notify the office if there are any changes to my credit card account.

Credit Card Number:_____ Expiration Date:_____ 3 digit security code:____
Name on Card: _____ Phone: _____
Cardholder Address: _____

_____ _____
Cardholder Signature ***Date***

Joyful Music Therapy
407-489-1783
www.joyfulmusictherapy.com

Client Name: _____ Date of Birth: _____

HEALTH GUIDELINES

The Board of Health considers the following signs to indicate communicable disease/illness: vomiting, fever over 100 degrees, diarrhea, sore throat, rash/swelling, red, or running eyes. Please be sure the client is symptom free for 24 hours before resuming therapy. Please note that if you come to therapy and he/she exhibits any of the above symptoms, it is at the therapist's discretion to send them home in order to protect themselves and our other clients from infectious illness.

Parent/Guardian Signature Printed Name Date

Consent for Photograph, Audio/Video Release

I _____ (Parent or Legal Guardian) give permission for _____ (Name of client) to be photographed, audio or video recorded by the therapists at Joyful Music Therapy, LLC. These photographs will be used for education and training purposes (i.e. clinical supervision, conference presentations), and may be used by Joyful Music Therapy, LLC for advertisement purposes (i.e. brochures, newspapers). At no time will the clients name be used and your identity will remain confidential. Tapes will be maintained in a locked facility.

Parent/Guardian Signature Printed Name Date

Permission for guardian to leave site during treatment

I _____ (Parent or Legal Guardian) acknowledge that I am the legal guardian of _____ (client). I understand that while the client is receiving therapy I may leave the premises. However, I will give Joyful Music Therapy, LLC a working cell phone number where I can be reached during my absence. In addition, I agree that I will return prior to the end of the session. I give consent and permission to Joyful Music Therapy, LLC for any additional treatment or transportation that may be needed in the event that the client named above is injured or needs medical attention. Also, I understand that the ability to continue to leave the premises while the client is at therapy is at the discretion of Joyful Music Therapy, LLC.

I hereby release Joyful Music Therapy, LLC, and any agents or assignees, from any and all claims for damages related to my leaving the premises during the above named clients therapy.

Parent/Guardian Signature Printed Name Date

_____

Primary Cell Phone Secondary Cell Phone Home Phone

Joyful Music Therapy
407-489-1783
www.joyfulmusictherapy.com

PRIVACY STATEMENT
CONSENT TO USE AND DISCLOSER OF HEALTHCARE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS:

We, at Joyful Music Therapy (JMT), look forward to providing Music Therapy sessions to you on a routine basis. We respect the privacy of you and your family and want you to feel comfortable regarding your private information.

- JMT maintains records describing health history, symptoms, examinations and test results, diagnoses, treatment and any future treatment plans
- Information regarding your treatment plans may be discussed among healthcare professionals who contribute to your care, upon written consent
- Demographic and billing information may be used by office staff
- Your file will be stored in a locked file cabinet

Parent/Guardian Signature Printed Name Date

PERMISSION FOR EXCHANGE OF INFORMATION

I authorize Joyful Music Therapy, LLC to release necessary and pertinent medical information to physicians, case managers and insurance companies as needed for _____

Approved information may be exchanged with the following people directly related to my child's care:

- Other Therapists
- School Name:_____
- Please list any other's: _____
  _____
  _____

Approved information includes **written documents** and/or **verbal discussion**.

Parent/Guardian Signature Printed Name Date