



ART THERAPY INTAKE PACKET

TO MAKE A REFERRAL FOR ART THERAPY, please complete the entire seven page packet, and mail it to 12200 Fairhill Rd. Cleveland, OH 44120. To expedite the process you can fax page 1 and 2 to 216/791-5610, and send the originals of the entire packet by mail.

CLIENT NAME			DOB / /	Age	M F	Preferred Location for AT Service Fairhill River's Edge Other _____		
Home Address			Parent/Guardian/Foster Parent					
			Address					
Home Phone			Home Phone		Work			
			Pager		Cell			
Name Referral Contact			Name Other Prof. Contact					
Agency			Agency					
Mailing Address			Mailing Address					
Office Phone		Cell	Pager		Office Phone		Cell	Pager
Person to contact to schedule appointment			Emergency Contact					
Name			Name					
Person transporting client			Relationship to Client					
Preferred DAY TIME AVAILABLE START DATE			Phone Number(s)					

REASON FOR REFERRAL

DIAGNOSIS

PSYCHO/SOCIAL HISTORY



ART THERAPY STUDIO

SINCE 1967

ART THERAPY CONSENT FORM

My permission is granted to:

- photograph or display _____'s artwork in the Art Therapy Studio's programs
- photograph _____'s participation in the Art Therapy Studio's programs

I understand that comments and case material may be used for scientific and educational purposes.

I have been assured that such artwork or reproductions will be presented in a professional manner for educational purposes, research, publication, or presentation.

Confidentiality of the client's name will be maintained unless otherwise agreed upon.

Client's Name _____ Age _____ DOB _____

Parent/Guardian Name _____

Address _____

Phone _____

Signed _____ Date _____
(Parent/Guardian)

Witness _____ Date _____

revised: 3/26/07



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CLIENT CONSENT FORM

Client's Name

I hereby consent to participate fully in the Art Therapy Studio's Therapeutic Arts Program. I understand that the various activities of this Program may be conducted at any of our three sites: Fairhill Center, River's Edge or Ursuline ArtSpace.

I agree to abide by all of the policies, procedures, rules and regulations of the Program as explained to me by the staff and set forth in any materials that I may receive.

I also hold the Art Therapy Studio free of any responsibility for any damage to or theft of my personal property, which may result from my participation in any of the activities of the Program. In brief, I am responsible for my personal property and belongings.

I understand the program staff are free to communicate with one another about my participation and progress, and to communicate my progress to my outpatient mental health professionals for the purpose of coordination of services and care.

I have been given the opportunity to discuss this consent form and to ask questions about the Program with a member of the program staff.

Client's Signature

Date

Parent/Guardian Signature

Witness

Date

Revised: 3/26/07



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POLICY FOR MISSED OR LATE APPOINTMENTS

The Art Therapy Studio's policy regarding missed or late appointments states that if you miss a scheduled appointment and do not give at least four (2) hours notification, charges for the full session will be incurred.

I/We understand that in order to cancel an appointment with no charge, I, or my caseworker must call the Art Therapy Studio at least 2 hours prior to the beginning of the scheduled appointment. If there is no answer, please leave your name, phone number and time of call on the answering machine. The office phone numbers are as follows:

Fairhill Art Studio	216/791-9303
River's Edge Art Studio	216/791-9303
An Alternate Number is	_____

Name of Client

Parent/Guardian Signature

Date

Therapist's Signature

Revised: 3/26/07



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AUTHORIZATION FOR RELEASE OF TREATMENT INFORMATION

(This form is to be used when you want the Art Therapy Studio to release treatment information.
Please copy form as needed.)

I, (parent/guardian) _____, hereby request and authorize the Art Therapy Studio to release the following information:

- Intake, assessment(s), progress reports, summaries, and treatment recommendation
- Photographs, copies and/or facsimiles or artwork
- Specific information as follows: _____

from the records of _____
(client name)

TO BE RELEASED TO:

(Name)

(Name of Agency or Practitioner)

(Street Address)

(City, State, ZIP)

I give permission for this information to be used for the following purpose: _____

This information appears in my _____ records.
(own, child's, client's)

This authorization expires on _____ (if not specified, authorization expires one year from the date of consent.)

Client Signature _____ Date _____

Parent/Guardian Signature _____

Revised: 3/26/07



ART THERAPY STUDIO

SINCE 1967

REQUEST FOR MEDICAL/PSYCHOLOGICAL INFORMATION

(This form is to be used to request an agency or practitioner to send medical info to the Art Therapy Studio. Please copy form as needed.)

MEDICAL INFO NEED FROM:

(Name of Agency or Practitioner)

(Street Address)

(City, State, ZIP)

CONCERNING: _____
(Name of Client)

Former or Maiden Name _____

Birthdate _____ Phone _____

Address _____

Medical Record Number at this Agency _____

Current Medical Insurance Provider _____

_____ # _____

Dates of Treatment _____

YOU ARE HEREBY AUTHORIZED TO RELEASE THE FOLLOWING INFORMATION TO THE STAFF OF THE ART THERAPY STUDIO:

- All Medical Records
- Psychological Assessments/Reports
- Summary of Therapy/Counseling Sessions
- Info Relating to Alcohol, Chemical Dependency Assessment & Treatment
- Other _____
- PT/OT/Speech Progress Reports
- Operative Reports
- Discharge Summary

This authorization expires on _____ (if not specified, authorization expires one year from the date of consent.)

Client Signature _____ Date _____

Signature Parent/Guardian

Revised: 3/26/07