2022-2023 School Year: *There is no need to complete this form if you do not want behavioral health services for your child.*

Dear Parents & Caretakers,

We would like to take the opportunity to provide information regarding mental health services provided through the MESH (Mobile Expanded School Health) unit as part of the Wilkes County Health Department. There are no out of pocket costs to families. If your child has insurance, we request that information so we may bill services while all copays are covered by this program. If you desire your child to be seen for counseling in the school setting or remotely, please complete the back page/consent form and return it to your student's school.

Should you complete this consent and your child wishes not to receive services, we will not provide services but do make every effort to present our services in a helpful and supportive nature to the students referred.

We will be providing mental health services to address the following issues:

Anger/aggressive behavior
Depression
Anxiety
Disruptive behavior in the classroom
Grief
Family
School performance (grades)
Substance Abuse
Other issues as they arise

Upon meeting with your child, should we feel that more intense services are needed, we may also refer services in our offices located in Wilkesboro, Elkin, Jefferson, Yadkinville, or Statesville. Should you feel that we could meet any needs of your students, please do not hesitate to reach out to us with any questions.

Respectfully,

Jodi Province
Licensed Clinical Mental Health Counselor
Certified Trauma Therapist

www.jodiprovincecs.com
jodi.province@gmail.com

DATE:_____ (Office Use Only: Provider):_____

NAME:_____
FIRST MIDDLE INITIAL LAST

ADDRESS:_____
CITY STATE ZIP

DATE OF BIRTH_____AGE_____RACE_____ HOME/CELL PHONE:_____

LEGAL GUARDIAN/RELATIONSHIP_____

SCHOOL ATTENDING_____GRADE_____

EMERGENCY CONTACT/TELEPHONE_____

PRIMARY PHYSICIAN/TELEPHONE_____

CURRENT MEDICATIONS_____

ALLERGIES_____

NATURE OF CONCERN REQUIRING

COUNSELING_____

INSURANCE INFORMATION:

Do you have insurance? YES: _____ NO: _____ Household Monthly Income:_____ _____

Insurance Company Name_____ Policy Number_____

Policy Holders Name_____D.O.B_____

SS#_____ Sex _____Race_____ Group Number_____

Does your child have Medicaid?_____

If yes, please provide the Medicaid#:_____

I/We consent that _____ (minor's name) may be treated as a client through the MESH unit with Jodi Province Counseling Services, PLLC. Please be aware that the law may provide parents/guardians the right to examine treatment records. It is our policy to provide parents/guardians access to information about treatment. However, we also ask parents/guardians to trust us and allow us to keep your confidences on specific information and we will provide them with general information about your treatment sessions. We ask for your cooperation to provide the timeliest treatment for your children. I am aware that my child will be giving the therapist consent to speak with the school as needed for continuity of care. I agree to the informed consent and client rights of Jodi Province Counseling Services, PLLC that is located at www.jodiprovincecs.com including the distance counseling policy.

Signature of Guardian **Date**