Prevention Intervention Center
514 Glover St, Marietta GA 30060 770-429-5846

CONTRACT FOR SERVICE PROVIDERS

As a member of the Cobb County Schools Coalition of Treatment Providers each participant (i.e., private practitioner or treatment facility) agrees to the following:

I. **Each evaluator will have experience in diagnosing and treating the disease of chemical dependence and /or mental health problems.**

II. **Members of the Coalition will be qualified practitioners who will attend an orientation session at the Prevention/Intervention Center and will offer a 50-minute free assessment to Cobb County students or employees and families.**

III. **We would like members of the Coalition to be present at all the coalition meetings; however, members should be present at a minimum of one meeting during the year.**

IV. **Attach a photocopy of your current license.**

V. **Send/fax forms to:** **The Prevention Intervention Center**
Fax # 678-594-8963 **Cobb County Public Schools**
P.O. Box 1088
Marietta, GA 30061

_____ _____
Name of Facility **Name**

_____ _____
Phone Number **Street Address**

_____ _____
Fax Number **City, State, Zip Code**

_____ _____
Email Address **Signature** **Date**

_____
URL/Web address

Please copy for your records and return original to P/I Center.

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Name of Facility_____ **Phone Number**_____

CHECK OFF YOUR TOP SPECIALTIES ONLY	
ADHD	☐
Anxiety Disorders	☐
Autism Spectrum Disorder	☐
Behavior Problems	☐
Blended Families	☐
Child and Adolescent Issues	☐
Child Abuse	☐
Cognitive Behavior Therapy	☐
COA	☐
Co-Dependency	☐
Conduct Disorders	☐
Cross Cultural Focus	☐
Dating and Relationship Issues	☐
Depression	☐
Developmental Disabilities	☐
Dissociative Disorders	☐
Divorce	☐
Dual Diagnosis	☐
EAP	☐
Eating Disorders	☐
Education Testing	☐
Family Dysfunction	☐
Families In Transition	☐
Family Therapy	☐
Grief Work	☐
In-Home Services	
Individual Therapy	☐
Inner Child Work	☐

Learning Disabilities	☐
Loss and Separation	☐
Medication Evaluation	☐
Parenting	☐
Play Therapy	☐
Post Traumatic Stress Disorder	☐
Psychological Testing	☐
Psychosomatic Illness	☐
Rape	☐
Religious Orientation	☐
School Avoidance	☐
Self-Esteem	☐
Severely Emotionally Disturbed	☐
Sexual Addiction	☐
Sexual Identity	☐
Sexual Abuse	☐
Social Skills	☐
Stress Management	☐
Substance Use	☐
Suicidal Behaviors or Ideation	☐
Tele mental Health Services	☐
Unattached or Sociopathic Children	☐
Women's/Men's Issues	☐
Other	☐
Other	☐
Age 0-6	☐
Age 6-12	☐
Age 12-18	☐
Speak any language other than English	☐ **Yes** ☐ **No**
Emergency Phone Number	
Low Cost/Sliding Scale Services	☐ **Yes** ☐ **No**

Are your services covered by Medicaid?	☐ **Yes** ☐ **No**
Are your services covered by any HMO?	☐ **Yes If yes, please list.** ☐ **No**

YOUR NAME
AND FACILITY_____

PLEASE LIST INSURANCE PROVIDERS THAT YOU TAKE

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RELEASE OF INFORMATION

I hereby authorize _____
(Assessment Center/Private Practitioner)

To disclose to _____
(School Counselor/Administrator)

At _____
(School)

The following items of information:

- ☐ **Information obtained from assessment**
- ☐ **Medical records**
- ☐ **Psychological test results**
- ☐ **Recommendations**
- ☐ **Other** _____
- ☐ **CONSENT NOT GIVEN AT THIS TIME – NO INFO MAY BE RELEASED**

Regarding _____
(Student Name)

This release permits ☐ single ☐ continuing (check one) disclosure.

This consent is given on _____
(Date)

This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon.

_____ _____
Signature of Student **Date**

_____ _____
Signature of Parent **Date**

_____ _____
Witness **Date**