Child New Patient Information

Patient Name:_____Birth Date: _____
Patient's Mailing Address: _____
City: _____State: _____Zip Code: _____

Mother's Name:_____Birth Date:_____
Mailing Address:_____
City:_____State:_____Zip Code:_____
Contact Numbers: Hm: _____ cell: _____ work: _____ Preferred Contact Number: _____

Father's Name:_____Birth Date:_____
Mailing Address:_____
City:_____State:_____Zip Code:_____
Contact Numbers: Hm: _____ cell: _____ work: _____ Preferred Contact Number: _____

Guardian's Name:_____Birth Date:_____
Mailing Address:_____
City:_____State:_____Zip Code:_____
Contact Numbers 1._____2._____3._____

Is it okay to reach you at the numbers above? Yes No
Is it okay to leave a message at the numbers above? Yes No
Which parent would you like your reminder call to be made to:_____

HIPPA Compliance

I acknowledge that I have received the HIPPA Notice Form.
***Signature*:_____*Date*:_____**

I acknowledge that I have received the Service Agreement Form, reviewed this information with my clinician, and agreed to the conditions specified.
***Signature*:_____*Date*:_____**

Authorization of Treatment and/or Assessment

I, (print name)_____, parent or legal guardian of (print patient's name)_____, a minor child, authorize treatment and/or assessment by (print therapist's name)_____.
***Signature*:_____*Date*:_____**

Payment Agreement

I, (print name) _____understand that I am responsible for payment at the time of each visit unless other arrangements have been made through my therapist. My insurance policy may not reimburse for all charges in which case I understand that I am responsible for the balance. The parent signing this statement is identified as being ultimately responsible for making sure any balances are paid.

***Signature*:_____*Date*:_____**