Counselor:______________

CHILD CLIENT INFORMATION FORM

Diag. Code:______________

(PLEASE PRINT NEATLY and COMPLETE ALL SPACES)

Child's Name: ____________________________________ Date: __________

First *Last* *MI.*

Street Address: ____________________________________

City: ____________________ State: __________ Zip: ________

Telephone #: (____) ______________ Message may be left on phone – yes _____ no _____

E-mail: ____________________ Preferred contact method: ______________

Sex: Male _____ Female _____ Social Security #_______ - ____ - _______ Birthdate: ____ / ____ / ____

Child's School: ____________________________________

School Address: ____________________________________

Street Address *City* *State* *Zip*

School Phone #: (______) ____________________

Name of Responsible Party: ____________________________________

Responsible Party Address: ____________________________________

Street Address *City* *State* *Zip*

Responsible Party's Phone #s Home: (_____) ____________ Work: (_____) ____________

Cell: (_____) ____________

Please tell us who referred you to our office so we can show our appreciation: ____________________

Previous Therapist Name: ____________________ Phone #: (____)____________

The above minor has my permission to be seen by therapist(s) at Associates in Professional Counseling X__________________

Parent/Guardian

POLICY HOLDER'S INSURANCE INFORMATION

____ **No insurance coverage**

PRIMARY INSURANCE:

Name of Policy Holder: ______________________________ Birthdate: ____ / ____ / ____

First *Last* *MI.*

Policy Holder's S.S. #_______ - ____ - _______ Policy/ Member ID #: ________________

Policy Holder's Employer: ________________________ Phone #: (____)____________

Insurance Company Name: ____________________________________

Insurance Company Address: ____________________________________

Street Address *City* *State* *Zip*

Insurance Company Phone #: (_____)____________ Group #: ________________

FILING FOR SECONDARY INSURANCE IS THE CLIENT'S RESPONSIBILITY

CONSENT AGREEMENT:

Your insurance coverage is an agreement between you and your insurance company. You are the one responsible for your account. We will be happy to file claims for you. However, if your insurance does not pay its portion within the 6 weeks of the filing date, you are responsible for your bill. Any money received from your insurance company after you have paid us will be promptly refunded to you.

I hereby authorize Associates in Professional Counseling to release any information required in the processing of claims.

I understand there will be a $50.00 charge for failed appointments or cancellations less than 24 hours before my appointment. There will be a $20.00 charge for returned checks.

I acknowledge receipt of the Associates in Professional Counseling Privacy Notification and General Policy Statement.

X ____________________________ X ______________

Parent or Guardian Signature Date

PAYMENT DUE UPON SERVICES RENDERED