

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: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ Message may be left on phones – 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 how you were referred to our office: \_\_\_\_\_

Previous Therapist Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

The above minor has my permission to be seen by therapist(s) at Associates in Professional Counseling and I have the Legal Authority to give this permission. 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 clinical Supervision/Consultation and processing of claims.

I understand there will be a minimum \$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 \_\_\_\_\_

**Parent or Guardian Signature**

X \_\_\_\_\_

**Date**

**PAYMENT DUE UPON SERVICES RENDERED**