You can complete this form on your computer if you have Adobe Reader version 5.0 or above. You will be able to print the completed form on your printer. You will not be able to save it once it is filled out unless you are using Acrobat Standard or Acrobat Professional (not the free program, Adobe Reader)

Child and Teen Information Form

Information About Your Child

Child's Name: ____ Today's Date: ________________

Home Address: ____ ______________, ____, __________

Age: _____ Date of Birth: ___/___/___ Home Ph: ________________________ Grade: ____________

School:_________________________________ Teacher:_______________ Physician:_______________

List any ongoing medical problems of your child:

List any medications your child takes on a regular basis:

List any medication allergies your child might have: [ ] none known [ ] _______________________________

Briefly describe the main problem(s) which have led you to seek psychological consultation about this child:

Information About Your Family

Please list each parent or guardian **actively involved** in this child's care. It is not necessary to repeat addresses if same as above.

Name: ________________________________ Age: _____ Relationship: ____________________
Address: ____ Phone: _____________
Employer: ____ Occupation: _________________________
Work Phone: _____________________________ May we leave messages at work? YES NO

Name: ________________________________ Age: _____ Relationship: ____________________
Address: ____ Phone: _____________
Employer: ____ Occupation: _________________________
Work Phone: _____________________________ May we leave messages at work? YES NO

Other people living at home:

Name	Age	Relationship
___________________________	_____	___________________________
___________________________	_____	___________________________
___________________________	_____	___________________________
___________________________	_____	___________________________
___________________________	_____	___________________________

continue on back side

How Your Child Was Referred to Our Office

Who referred you to our office? ____
It is customary to send a note of thanks to referring professionals. May we do this in your case? YES NO

Information About Billing and Insurance

How do you prefer to cover your expenses? [ ] Cash [ ] Insurance [ ] Employee Assistance [ ] Other____________

If insurance, name of primary insurance carrier:____

Note: If you have one, please present your insurance card so that we may make a copy for our records.

Name of subscriber:___________ ______________________________ Subscriber's date of birth: _________________

Subscriber's Employer: ____

Policy Number, Social Security Number, or Health Record Number of the subscriber: _____________________________

Group Number: ______________________ Co-pay amount _______ ($/%) Deductible yet to be met: $_________

Does the policy allow family therapy? YES NO

Note: If you do not know what your insurance covers, please call them to obtain this information before your first appointment.
If this child has a secondary insurance, please bring this information to the first appointment.

Name of person responsible for payment of fees:____

Social Security Number of above-named person: _________-________-_____________

Note: Especially in blended family situation, it can be difficult to identify the individual ultimately responsible for payment of healthcare related fees. This information helps us clearly identify the responsible party in your child's case.

Please Read and Sign the Following

I am requesting psychological services on behalf of my child. I have been provided information regarding office policies, including fees, missed appointments or late cancellations, the right to refuse treatment, choosing the best treatment provider, extent of confidentiality, protecting my child's health care record, and information about my child's clinician.

X____ ____________________
Signature Date

Insurance Authorization and Benefit Assignment

If you plan to use insurance benefits to help cover evaluation and treatment costs, you will need to allow us to communicate with your insurer. Your signature below will allow us to bill your insurance company and to collect payment from them directly. Please review the following and sign below. Ask us about any questions you might have.

My signature below allows: (1) NWPR to release basic, confidential information about my child, such as date and type

of service, diagnosis, and other information required to process my child's claim; (2) My insurance company to pay benefits directly to NWPR to be applied to my child's account; and (3) NWPR to bill my insurance company in the future without me having to sign for this each time. I understand that I am responsible for any charges not covered or reimbursed by my insurer. Also, I understand that this authorization is valid until withdrawn by me in writing, and that I my revoke this release at any time except to the extent that action has already been taken in reliance on my consent.

X____ ____________________

Signature Date