Child & Teen Information Form

Office Use: ID verified: _____ Type:_____

Child's Name: _____ Today's Date: _____

Home Address: _____ _____, _____, _____
Street City State Zip

Age: _____ Date of Birth: _____/_____/_____ Home Phone: _____ Grade: _____

School:_____ 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 concern or question leading you to seek consultation about this child:

_____

_____

_____

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: _____ Personal Phone:_____

Employer: _____ Occupation: _____

Work Phone: _____ If needed, may we leave messages for you at work? ☐YES ☐NO

Name: _____ Age: _____ Relationship: _____

Address: _____ Personal Phone:_____

Employer: _____ Occupation: _____

Work Phone: _____ If needed, may we leave messages for you at work? ☐YES ☐NO

E-mail of primary contact person: _____@_____ . _____

Providing your e-mail is optional. E-mail communication is convenient but should not be considered confidential. Providing your e-mail address assumes you understand and accept the risks to your privacy. Please discuss with your clinician their policies about how and when to communicate in this manner.

Do you share custody/guardianship with another person not listed above (i.e., an ex-partner, etc.)? ☐YES ☐NO
If yes, does this person know about and consent to you bringing your child for these services? ☐YES ☐NO

If applicable, please provide contact information for any legal guardian of this child not listed previously:

Name: _____ Relationship to child: _____

Address: _____ Contact Phone:_____

If you share custody of this child with another person, please check your parenting plan and/or consult with your attorney regarding how health care decisions are to be made. In most cases, it is both a courtesy and legal right for your child's other parent to know about, consent to, and be allowed to participate in the process of evaluation and treatment.

Other people living in the home:

Name	*Age*	*Relationship*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who referred you to our office?_____

I may wish to send a note of thanks to referring professionals. May we do this in your case? ☐YES ☐NO

Emergency Contact Person: _____ Phone # (_____) _____-_____

How do you prefer to cover your child's expenses?

☐Cash ☐Insurance ☐Employee Assistance ☐DSHS/CPS ☐Attorney ☐Other_____

If you are using insurance, be sure to provide our staff with all insurance cards for photocopying. If you also have a secondary insurance, please also list this below and present the card for photocopying. No need to complete the following if you can provide your card(s) to copy.

Name of **Primary** Insurance Carrier: _____

Name of Insurance Subscriber:_____ Subscriber's Birthdate:_____

Subscriber's Employer: _____ Policy Number:_____

Name of **Secondary** Insurance Carrier: _____

Name of Insurance Subscriber:_____ ___Subscriber's Birthdate:_____

Subscriber's Employer: _____ Policy Number:_____

Even if you are using insurance or expect your child's services to be paid by someone else, please provide the name of the parent or guardian who is financially responsible for this child:

_____

Required: Social Security Number of the financially responsible person: _____--_____--_____

***Why we need your Social Security Number* (SSN)**: If you are not paying cash in full, your clinician becomes a business offering you credit and carrying outstanding balances on your behalf. This allows correct identification of the person responsible for this account. Your SSN is kept secure in the child's file and is required even if you have insurance and/or do not expect to have any co-pays. Not providing this number assumes you are planning to pay cash in full at time of each service.

If you wish others to have access to scheduling your child's appointments or to billing information, please list them here:

_____ _____

Name Relationship

_____ _____

Name Relationship

Would you like to keep a secured credit card or Health Savings Account number on file to charge for co-pays and balances due? If YES…please see the attached form.

Keeping a credit card on file is completely optional. It can be a convenient way to pay future balances, if you can't pay your co-pay at time of service, or prefer not having to come by the office or mail in a payment. It can also prevent late fees, interest from accruing on past-due accounts, as well as avoid costly collection actions. Your clinician can share more about how credit cards are handled.

Signatures

There are 3 areas we need you signature as required by State regulation. These include 1) acknowledging that you received my Office Policies and Informed Consent materials, 2) allowing me to bill your insurance, and 3) permitting us to have sessions by telehealth in the event we want to do this.

The person signing this form must have legal authority to do so. In most cases, this will be the child's custodial parent and legal guardian, or another court-appointed party.

1. **I am requesting mental health services on behalf of my child. I have been provided information regarding Office Policies and Informed Consent, including fees, policies for missed appointments or late cancellations, the right to refuse treatment, extent of confidentiality, and protecting my child's health care record. I understand I am a private client of my clinician, not of NWPR or any other NWPR-affiliated clinician.**

_____ _____

Signature Date

2. 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 if you have any questions.

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 insurance claims; (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. This authorization is valid until withdrawn by me in writing. I may revoke this release at any time except to the extent that action has already been taken in reliance on my consent.

_____ _____

Signature Date

3. Consent for Audio and Telehealth Sessions

An audio session is used to describe a mental health session conducted via telephone or over the internet. State law requires that I have your permission to engage in this service with you and/or your child. Even if your child is mostly coming for in-person appointments, having your signature on file now means we can use this option in the future if we want without additional special signature (e.g., snow days, illness, being out of town, etc.) If we use audio sessions, please maintain a quiet and confidential environment without distractions during our sessions so we can make the most of our time together and be sure that our conversation cannot be easily heard by others to protect your child's confidentiality.

Your signature below indicates you give your permission to engage in audio sessions with me and that you give permission to bill your insurance company for audio sessions. If you have questions as to whether your insurance policy covers audio session, please contact your insurance company to verify your benefits prior to your appointment.

_____ _____

Signature Date

Credit Card/HSA Guarantee Form

I understand my credit card number will be kept securely and confidentially on file.

I authorize billing my credit card under one or both of the following conditions:

Initial one or both options

_____ I ask that some or all of my personal balance be charged to my credit card as an alternative to writing a check or paying cash at the time of service, or as a convenient alternative to mailing or brining in a payment.

_____ If I have an outstanding balance more than 60 days past due, and I have not already agreed With my clinician upon a plan of payment, then I allow my credit card to automatically be charged for the balance due to clear my account to avoid the collections process.

Card Information

Type Of Card: _____ Visa _____MasterCard _____American Express _____ Other _____

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____/ _____ CCV Code (number on the back – 3 digits) _____

Name on Card _____

"I hereby authorized Northwest Psychological Resources to charge the balance of my account for any fees not paid at the time of service under the conditions described above. I also agree to inform NWPR and provide updated information if this card is terminated, expires or changes in any way"

_____
Patient

_____ _____
Signature of Cardholder Date

_____
Clinician's Name