Child & Teen Information Form

Office Use: ID verified:_____ Type:_____ Clinician:_____

Information About Your Child

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:

_____

_____

_____

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: _____ 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?_____

It is customary to send a note of thanks to referring professionals. May we do this in your case? ◎YES ◎NO

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

Your clinician wants to ensure that he or she is providing the best care possible based on your child's particular culture and language preference. Please complete the following information about your child: (check one)

◎ Native American/Alaska Native ◎ Asian ◎ White/Caucasian ◎ Black/African American
◎ Native Hawaiian/Pacific Islander ◎ More than one race Is this child Hispanic or Latino? ◎ Yes ◎ No

Does this child prefer to communicate in a language other than English? ◎ Yes ◎ No - If yes, which?_____

Billing and Insurance Information

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.

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:_____

If you do not know what your insurance covers, please call them to obtain this information if at all possible before your first appointment. A customer services representative should be able to explain your deductibles and expected co-pays.

Provide the name of person responsible for payment on this child's account:

◎ Self ◎ Other: _____

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. Having your SSN (or that of the financially responsible party) allows correct identification of the person responsible for this account. Your SSN is kept secure. Not providing this number assumes you are planning to pay cash in full at time of each service.

Would you like to keep a secured credit card number on file to charge for co-pays and balances due? ◎ Yes ◎ No

Keeping a credit card on file is completely optional. It can be a convenient way to pay future balances, 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 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.

Authorizations and Signatures --------- Please read and sign the following

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.

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.

_____ _____

Signature Date

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

Thank you!

We look forward to being of service to you and your family.

For more information, please visit our websites at: www.nwpsych.com or www.cfmal.com

Office Policies, Informed Consent for Treatment, and Protecting the Privacy of Your Health Record

Signature Page

Included with this intake information is a form entitled **Office Policies, Informed Consent for Treatment, and Protecting the Privacy of Your Health Record**. Let us know if you did not get this document.

Please look over this information and important policies. Take this document home with you. However, governmental regulations require that we verify you received this material.

Please print and sign your name below. Your clinician will sign their name and keep this page in your file.

I certify that I have received a copy of "Office Policies, Informed Consent for Treatment, and Protecting the Privacy of Your Health Record."

_____

Printed Name of Patient or Legal Guardian

_____ _____

Signature of Patient or Guardian Date

_____ _____

Signature of Clinician Date