CHILD/ADOLESCENT INFORMATION FORM

Failure to complete this form in full can lead to difficulties receiving payments from insurance companies.

Child's/Adolescent's full Name: _____ Today's Date: _____

Date of Birth: _____/_____/_____ Age: _____ Male/Female Social Security #: _____-_____-_____

Mother's Name: _____ Date of Birth: _____/_____/_____

Home Address: _____City & Zip: _____

Home Phone: _____**Cell Phone**: _____ Social Security #:_____

Employer: _____ Occupation: _____

Father's Name: _____ Date of Birth: _____/_____/_____

Home Address (if different): _____City & Zip: _____

Home Phone: _____Cell Phone: _____ Social Security #:_____

Employer: _____ Occupation: _____

Child's School: _____ Grade: _____ Teacher: _____

Name of Family Doctor: _____Phone: _____

Siblings and/or others living in the home:

Name: _____ Age: _____ Relationship to Client: _____

Name: _____ Age: _____ Relationship to Client: _____

Name: _____ Age: _____ Relationship to Client: _____

Name: _____ Age: _____ Relationship to Client: _____

Insurance Information/Responsible Party Information

Full Name of Insured/Responsible Party _____SS#: _____Male/Female

Home Address (if different): _____City & Zip: _____

Relationship to Client: _____ Employer'sName: _____

Primary Insurance: _____ Primary Insurance Phone#: _____

Claims Address (include city, state & zip):_____

I.D.#: _____ Policy or Group #: _____

Deductible: _____ Met? Y /N Co-pay:_____ Type of Insurance: HMO PPO POS EAP

***Authorization Needed? Yes/ No Obtained? Yes/ No Auth #:** _____

***Pre-authorizations are the responsibility of the client/responsible party**

OFFICE BILLING AND INSURANCE POLICY

By my signature below: I understand that it is my responsibility to be aware of the limits of my insurance coverage. I authorize the use of this form on all insurance submissions. I authorize the release of information to my insurance company. I understand that I am responsible for the full amount of my bill for services provided. I understand that I, not my insurance company, am responsible for and will be billed for any appointments which I cancel or miss with less than 24 hours notice to the service provider. I authorize direct payment to my service provider. Client billing is usually

completed at the beginning of each month and the balance is due upon receipt. ***Copays are due at each session.*** I hereby permit a copy of this form to be used in place of the original.

Signature: _____ Date: _____