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CHILD CLIENT INTAKE INFORMATION FORM

Child's Name _____ DOB: _____ M ___ F ___

Parent's Name(s): _____ Phone: _____

_____ Phone: _____

Permission to call/text: Y ___ N ___ Permission to mail and/or email:

Address: _____ Y ___ N ___

City/Zip: _____

Email: _____

School: _____ Grade/teacher: _____

Briefly describe the reason(s) for seeking help:

Name of Health Insurance: _____ ID#: _____

Group # / Name: _____ Primary SSN _____

Primary insured's Name: _____ DOB: _____ M ___ F ___

Authorization #: _____ Co-Pay: _____

Who has legal custody of child: _____

Primary Care Physician's Name/Date of last Appt.: _____

Allergies: _____ Medical Problems: _____ Medications: _____

By signing below, I authorize the release of any medical (PHI) or other information necessary to process an insurance claim. I attest that my therapist will do all that is necessary to file insurance benefits on my behalf, and I authorize payment of medical benefits to my therapist directly. However, as the insured, I am responsible for paying any co-pays due on the date of service. I am also ultimately responsible for any denied claims that were properly filed in a timely manner.

Authorized Signature

Date