Date of Intake: _____ Doctor: _____

Client Information Form – Child/Minor

Client: Legal Name: _____ Preferred Name_____
SSN: _____ Birth Date: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Phone No: (Home) _____ (Cell) _____
Custody held by: _____

Physician: Name: _____ Phone Number: _____
Were you referred to Auburn Psychology Group by your physician? _____

Mother: Name: _____ Phone Number**:**_____
Address: _____
Phone No: (Home) _____ (Work) _____ (Cell) _____
At which of these numbers can you most easily be reached? _____
At which of the numbers can we leave a brief message if necessary? _____

Father: Name: _____ Phone Number**:** _____
Address: _____
Phone No: (Home) _____ (Work) _____ (Cell) _____
At which of these numbers can you most easily be reached? _____
At which of the numbers can we leave a brief message if necessary? _____

Email address _____
Would you like a reminder **text** for future appointment times? _____***
***If "Yes" who is your cell phone carrier? _____

Express Prior Consent To Contact Consumer by Cell Phone:

You agree, in order for us to service you and your account, or to collect monies you may owe, Auburn Psychology Group, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

Billable Party: Name: _____ Relationship to Client**:**_____
Address: _____
Phone No: (Home) _____ (Work) _____ (Cell) _____

Agreement To Pay:

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collections agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

Insurance Policy holder's name: _____Relationship to the patient: _____
Policy owner's place of work _____
Birth Date: _____
Please provide a copy of your insurance card.

*****PLEASE SIGN NEXT PAGE**

Signature: Your signature below indicates that you have received, read, and agreed to the terms of the following notices:

1. Alabama Notice Form (HIPAA)
2. Psychologist/Client Services Agreement
3. Fee Agreement

_____ _____

Signature of client (age 14 or older) or legal representative Date