The Being Place—where humans can learn healthier ways of being

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PLEASE COMPLETE THE FOLLOWING FORM ABOUT YOUR CHILD OR ADOLESCENT. IF CERTAIN QUESTIONS DO NOT APPLY, PLEASE WRITE NA IN THE BLANK.

CHILD'S NAME_____ DATE: _____ GENDER: ____F ____M

DATE OF BIRTH:_____ AGE:_____ GRADE IN SCHOOL_____ NAME OF SCHOOL: _____

FORM COMPLETED BY (IF SOMEONE OTHER THAN CLIENT) AND RELATIONSHIP TO CLIENT: _____

PARENT 1 ADDRESS: _____CITY: _____ STATE AND ZIP CODE: _____

PHONE (PERSONAL) _____ WORK: _____ EXT.: _____

EMAIL: _____

WHICH PHONE NUMBERS CAN WE LEAVE A MESSAGE ON? PERSONAL ___ YES ___ NO | WORK ____ YES ____ NO

PARENT 2 ADDRESS: _____CITY: _____ STATE AND ZIP CODE: _____

PHONE (PERSONAL) _____ WORK: _____ EXT.:_____

EMAIL: _____

WHICH PHONE NUMBERS CAN WE LEAVE A MESSAGE ON? PERSONAL ___ YES ___ NO | WORK ____ YES ____ NO

EMERGENCY CONTACT INFORMATION (DIFFERENT FROM PRIMARY CARETAKER) NAME: _____ PHONE _____

ADDRESS _____ RELATIONSHIP TO CHILD: _____

CHILD'S LIVING ARRANGEMENTS (MARK ALL THAT APPLY):

ARE PARENTS DIVORCED OR SEPARATED? ____ NO ____ YES IF YES, IS THERE JOINT CUSTODY? ____ YES ____ NO

DOES THE CHILD LIVE WITH: ____ BIOLOGICAL PARENT ____ STEP PARENT ____ ADOPTIVE PARENT ____ FOSTER PARENT | OTHER: _____

IS THERE ANY INFORMATION ABOUT THE PARENTS' RELATIONSHIP WITH YOUR CHILD THAT MIGHT BE BENEFICIAL IN COUNSELING? ____ YES ____ NO

IF YES, PLEASE EXPLAIN: _____

PARENT 1:

NAME: _____ AGE: ____ OCCUPATION: _____ FULL TIME: ____ PART-TIME: _____
WHERE EMPLOYED: _____ PARENT 1'S EDUCATION: _____
IS THE CHILD CURRENTLY LIVING WITH THIS PARENT? ____ YES ____ NO
IS THERE ANYTHING NOTABLE ABOUT YOUR CHILD'S RELATIONSHIP WITH THIS PARENT? ____ YES ____ NO
IF YES, PLEASE EXPLAIN: _____
HOW IS YOUR CHILD DISCIPLINED BY THIS PARENT? _____
FOR WHAT REASONS IS THE CHILD DISCIPLINED BY THIS PARENT? _____

PARENT 2:

NAME: _____ AGE: ____ OCCUPATION: _____ FULL TIME: ____ PART-TIME: _____
WHERE EMPLOYED: _____ PARENT 1'S EDUCATION: _____
IS THE CHILD CURRENTLY LIVING WITH THIS PARENT? ____ YES ____ NO
IS THERE ANYTHING NOTABLE ABOUT YOUR CHILD'S RELATIONSHIP WITH THIS PARENT? ____ YES ____ NO IF YES, PLEASE EXPLAIN: _____
HOW IS YOUR CHILD DISCIPLINED BY THIS PARENT? _____
FOR WHAT REASONS IS THE CHILD DISCIPLINED BY THIS PARENT? _____

IF THERE IS OTHER PARENTAL INFORMATION TO NOTE, PLEASE USE THE BACK OF THIS PAGE:

PSYCHOLOGICAL HISTORY INITIAL INFORMATION/EVALUATION

CLIENT'S SIBLINGS AND OTHERS WHO LIVE WITH CHILD/ADOLESCENT

NAMES OF SIBLINGS	AGE	GENDER: CIRCLE ONE	LIVES	QUALITY OF RELATIONSHIP WITH THE CLIENT
		FEMALE MALE	___ HOME ___ AWAY	__POOR __AVERAGE __ GOOD
		FEMALE MALE	___ HOME ___ AWAY	__POOR __AVERAGE __ GOOD
		FEMALE MALE	___ HOME ___ AWAY	__POOR __AVERAGE __ GOOD
		FEMALE MALE	___ HOME ___ AWAY	__POOR __AVERAGE __ GOOD
		FEMALE MALE	___ HOME ___ AWAY	__POOR __AVERAGE __ GOOD
OTHERS LIVING IN HOUSEHOLD (INCLUDING STEP-PARENTS) WHAT IS THEIR RELATIONSHIP				
NAME AND RELATIONSHIP	AGE	GENDER: CIRCLE ONE		QUALITY OF RELATIONSHIP WITH THE CLIENT
		FEMALE MALE		__POOR __AVERAGE __ GOOD
		FEMALE MALE		__POOR __AVERAGE __ GOOD
		FEMALE MALE		__POOR __AVERAGE __ GOOD
		FEMALE MALE		__POOR __AVERAGE __ GOOD

FAMILY SPIRITUALITY/RELIGIOUS AFFILIATION: _____

FAMILY HEALTH HISTORY

HAVE ANY OF THE FOLLOWING MEDICAL/EMOTIONAL PROBLEMS OCCURRED AMONG THE CHILD'S BLOOD RELATIVES? CHECK THOSE WHICH APPLY AND INDICATE THE FAMILY MEMBER WITH THIS CONCERN:

___ ADDICTIONS (SPECIFY)
___ ALLERGIES
___ ATTENTION-DEFICIT DISORDER
___ ANXIETY
___ ASTHMA
___ AUTISM SPECTRUM DISORDERS
___ BLINDNESS
___ CANCER
___ CEREBRAL PALSY
___ CLEFT LIP
___ CLEFT PALATE
___ DEPRESSION
___ GLANDULAR PROBLEMS
___ HEART DISEASE
___ HIGH BLOOD PRESSURE
___ INTELLECTUAL DISABILITIES
___ KIDNEY DISEASE
___ LEARNING DISABILITIES
___ MENTAL ILLNESS
___ MIGRAINES
___ MULTIPLE SCLEROSIS
___ MUSCULAR DYSTROPHY
___ SCHIZOPHRENIA
___ SEIZURES
___ SPINA BIFIDA
___ SUICIDE
OTHER: PLEASE EXPLAIN: _____
_____
_____
_____

YOUR CHILD'S DEVELOPMENTAL/MEDICAL HISTORY

PREGNANCY/BIRTH

WHAT WAS THE LENGTH OF PREGNANCY WITH YOUR CHILD _____
BIOLOGICAL MOTHER'S AGE AT BIRTH? ____ BIOLOGICAL FATHER'S AGE AT BIRTH? ____ BIRTH ORDER _____ OUT OF ____ TOTAL CHILDREN
HOW MANY POUNDS DID THE MOTHER GAIN DURING PREGNANCY? _____
WHILE PREGNANT DID THE MOTHER SMOKE? ___ YES ___ NO IF YES, WHAT AMOUNT? _____
DID THE MOTHER USE DRUGS OR ALCOHOL WHILE PREGNANT? ____ YES ____ NO IF YES, TYPE/AMOUNT _____
WHILE PREGNANT, DID THE MOTHER HAVE ANY MEDICAL OR EMOTIONAL DIFFICULTIES? (E.G., ANXIETY, DEPRESSION SURGERY, HYPERTENSION, PRE-ECLAMPSIA, MEDICATION.) ____ YES ____ NO
IF YES, DESCRIBE: _____
LENGTH OF LABOR: _____ INDUCED ____ YES ____ NO CAESAREAN ____ YES ____ NO
DESCRIBE ANY PHYSICAL OR EMOTIONAL COMPLICATIONS WITH DELIVERY: _____
_____
DESCRIBE ANY COMPLICATIONS FOR THE MOTHER OR THE BABY AFTER BIRTH: _____
_____
LENGTH OF HOSPITALIZATION: MOTHER _____ BABY: _____

PSYCHOLOGICAL HISTORY INITIAL INFORMATION/EVALUATION

INFANCY/TODDLERHOOD CHECK ALL WHICH APPLY:

____ BREASTFED	____ BOTTLE FED	____ MILK ALLERGIES	____ VOMITING	____ DIARRHEA
____ RASHES	____ COLIC	____ CONSTIPATION	____ NOT CUDDLY	____ VERY CUDDLY
____ RARELY CRIED	____CRIED OFTEN	____ GOOD SLEEPER	____ TROUBLE SLEEPING	___IRRITABLE WHEN AWAKENED
____ LETHARGIC	____ OVERACTIVE	____ RESISTED SOLID FOOD	OTHER: _____	

MAJOR DEVELOPMENTAL MILESTONES: PLEASE NOTE THE AGE AT WHICH THE FOLLOWING BEHAVIORS TOOK PLACE:

SAT ALONE: _____ DRESSED SELF: _____
TOOK 1ST STEPS: _____ TIED SHOE LACES: _____
SPOKEN WORDS: _____ RODE TWO-WHEELED BICYCLE: _____
WEANED: _____ DRY DURING DAY: _____
FED SELF: _____ DRY DURING NIGHT: _____

COMPARED WITH OTHERS IN THE FAMILY, CHILD'S DEVELOPMENT WAS: _____ SLOW _____ AVERAGE ____ FAST

HAVE THERE BEEN ANY ISSUES THAT COULD HAVE AFFECTED YOUR CHILD'S DEVELOPMENT (E.G., PHYSICAL/SEXUAL ABUSE, INADEQUATE NUTRITION, NEGLECT, ETC. ____ YES ____ NO IF YES, PLEASE DESCRIBE: _____

MEDICAL/PHYSICAL HEALTH: PLEASE PLACE A CHECK BESIDE ALL OF THE FOLLOWING MEDICAL ISSUES YOUR CHILD HAS HAD:

____ ASTHMA	____ MENINGITIS	____ PNEUMONIA	____ BRONCHITIS	____ HEART TROUBLE
____ AUTISM	____ CEREBRAL PALSY	____ HEPATITIS	____ MULTIPLE SCLEROSIS	____ CHICKEN POX
____ POLIO	____ SCARLET FEVER	____ CROUP	____ SEVERE HEAD INJURY	____ LYME DISEASE
____ HIVES	____ DIABETES	____ LEAD POISONING	____ SEVERE COLDS	____ DIPHTHERIA
____ SEIZURES	____ INFLUENZA	____ DIZZINESS	____ MUSCULAR DYSTROPHY	____ STDS
____ MEASLES	____ MUMPS	____ RHEUMATIC FEVER	____ THYROID DISORDERS	____ EAR INFECTIONS
____ EAR ACHES	____ WEARING GLASSES	____ NOSE BLEEDS	____ WHOOPING COUGH	

LIST ANY CURRENT HEALTH CONCERNS: _____
LIST ANY RECENT HEALTH OR PHYSICAL CHANGES: _____
DOES YOUR CHILD HAVE ANY VISION DIFFICULTIES? ____ YES ____ NO IF YES, DESCRIBE: _____
DOES YOUR CHILD HAVE ANY HEARING DIFFICULTIES? ____ YES ____ NO IF YES, DESCRIBE: _____
PRIMARY CARE PHYSICIAN: _____ CLINIC: _____ DATE OF LAST PHYSICAL EXAM: _____

CURRENT PRESCRIBED MEDICATIONS	DOSE	DATES	PURPOSE	SIDE EFFECTS

IF YOU CHILD IS PRESCRIBED MENTAL HEALTH MEDICATIONS (I.E., FOR ADHD, ANXIETY, DEPRESSION, ETC.) PLEASE INCLUDE THAT PROVIDER'S INFORMATION HERE, IF DIFFERENT THAN PRIMARY CARE PHYSICIAN.

PHYSICIAN NAME: _____ CLINIC: _____ DATE OF LAST MEDICATION CHECK: _____

CHEMICAL USE HISTORY

DOES YOUR CHILD/ADOLESCENT USE OR HAVE A PROBLEM WITH ALCOHOL OR DRUGS? ____ YES ____ NO

IF YES, DESCRIBE: _____

PSYCHOLOGICAL HISTORY INITIAL INFORMATION/EVALUATION

YOUR CHILD'S EDUCATIONAL HISTORY

CURRENT SCHOOL _____ SCHOOL'S PHONE NUMBER _____

TYPE OF SCHOOL: ____ PUBLIC SCHOOL ____ PRIVATE SCHOOL ____ HOME SCHOOL ____ OTHER (SPECIFY)
_____

GRADE ____ TEACHER NAME: _____ SCHOOL COUNSELOR NAME: _____

IN SPECIAL EDUCATION: ____ YES ____ NO IF YES, DESCRIBE: _____

IN GIFTED PROGRAM: ____ YES ____ NO IF YES, DESCRIBE: _____

HAS YOUR CHILD EVER REPEATED A GRADE ____ YES ____ NO IF YES, DESCRIBE: _____

WHAT IS YOUR CHILD'S FAVORITE SUBJECTS? _____

WHAT IS YOUR CHILD'S LEAST FAVORITE SUBJECTS? _____

HAVE THERE BEEN ANY RECENT CHANGES IN YOUR CHILD'S GRADES? ____ YES ____ NO IF YES, DESCRIBE: _____

HAS YOUR CHILD RECEIVED PSYCHOLOGICAL TESTING OR TESTING FROM THE AEA? ____ YES ____ NO

IF YES, DESCRIBE: _____

ADDITIONAL COMMENTS: _____

_____

CHECK THE DESCRIPTIONS WHICH SPECIFICALLY RELATE TO YOUR CHILD

FEELINGS ABOUT SCHOOL WORK:

___ ANXIOUS ___ PASSIVE ___ ENTHUSIASTIC ___ FEARFUL
___ EAGER ___ NO EXPRESSION ___ BORED ___ REBELLIOUS
___ OTHER (DESCRIBE) _____

APPROACH TO SCHOOL WORK:

___ ORGANIZED ___ INDUSTRIOUS ___ RESPONSIBLE ___ INTERESTED
___ SELF-DIRECTED ___ NO INITIATIVE ___ REFUSES ___ DOES ONLY WHAT IS EXPECTED
___ SLOPPY ___ DISORGANIZED ___ COOPERATIVE ___ DOESN'T COMPLETE ASSIGNMENTS
___ OTHER (DESCRIBE) _____

PERFORMANCE IN SCHOOL (PARENT'S OPINION)

___ SATISFACTORY ___ UNDERACHIEVER ___ OVERACHIEVER
___ OTHER (DESCRIBE) _____

CHILD'S PEER RELATIONSHIPS

___ SPONTANEOUS ___ FOLLOWER ___ LEADER ___ DIFFICULTY MAKING FRIENDS
___ MAKES FRIENDS EASILY ___ LONG-TIME FRIENDS ___ SHARES EASILY
___ OTHER _____

YOUR CHILD'S COUNSELING/PRIOR TREATMENT HISTORY

HAS YOUR CHILD EVER RECEIVED PSYCHOLOGICAL OR PSYCHIATRIC HELP OR COUNSELING OF ANY KIND BEFORE? IF YES, PLEASE GIVE DETAILS, INCLUDING DATES OR TIME PERIOD OF THE PREVIOUS COUNSELING, THE PROBLEMS FOR WHICH YOUR CHILD WAS SEEN, WHERE AND BY WHOM THEY WERE TREATED, THE NATURE OF THE THERAPY, AND ANY OTHER ADDITIONAL INFORMATION THAT MIGHT BE RELEVANT TO OUR WORK.

_____

_____

HOW WOULD YOU RATE THIS PREVIOUS HELP? __ VERY HELPFUL __ SOMEWHAT HELPFUL __ NOT VERY HELPFUL __ USELESS __ HARMFUL

PSYCHOLOGICAL HISTORY INITIAL INFORMATION/EVALUATION

BEHAVIORAL/EMOTIONAL FUNCTIONING

PLEASE CHECK ANY OF THE FOLLOWING PROBLEMS THAT ARE TYPICAL FOR YOUR CHILD AT THIS TIME:

__ AGGRESSIVE/ANGRY
__ ALCOHOL USE
__ ANXIETY
__ BEDWETTING
__ BLINKING, JERKING
__ BULLIES, THREATENS
__ CARELESS, RECKLESS
__ DEFIANT
__ DEPRESSION
__ DESTRUCTIVE
__ DIZZINESS
__ DRUG USE
__ EATING DISORDER
__ FATIGUE
__ FEARFUL
__ FREQUENT INJURIES
__ FRUSTRATED EASILY
__ HALLUCINATIONS
__ HEAD BANGING
__ HOPELESSNESS
__ HURTS ANIMALS
__ IMPULSIVE
__ IRRITABLE
__ LEARNING PROBLEMS
__ LIES FREQUENTLY
__ LONER
__ LOW SELF-ESTEEM
__ MOODY
__ NIGHTMARES
__ OFTEN SICK
__ OPPOSITIONAL
__ OVER ACTIVE
__ OVER WEIGHT
__ PANIC ATTACKS
__ PHOBIAS
__ POOR APPETITE
__ QUARRELS
__ SAD
__ SELFISH
__ SEPARATION ANXIETY
__ SETS FIRES
__ SEXUAL ACTING OUT
__ SICK OFTEN
__ SHORT ATTENTION SPAN
__ SHY, TIMID
__ SLEEPING PROBLEMS
__ SLOW MOVING
__ SOILING
__ SPEECH PROBLEMS
__ STEALS
__ STOMACH ACHES
__ SUICIDAL THREATS, ATTEMPTS
__ TALKS BACK
__ TEETH GRINDING
__ THUMB SUCKING
__ UNSAFE BEHAVIORS
__ UNUSUAL THINKING
__ WEIGHT LOSS
__ WITHDRAWN
__ WORRIES EXCESSIVELY

PLEASE DESCRIBE ANY OF THE ABOVE (OR OTHER) CONCERNS: _____
_____

HOW ARE PROBLEM BEHAVIORS GENERALLY HANDLED?_____
_____

HAS YOUR CHILD/ADOLESCENT EXPERIENCE TRAUMA? (I.E., LOSS OF LOVED ONES, PETS, ETC.; PHYSICAL/SEXUAL/EMOTIONAL ABUSE: __ YES __ NO
AT WHAT AGE? ____ IF YES, DESCRIBE YOUR CHILD'S/ADOLESCENT'S TRAUMA AND/OR THEIR REACTION: _____
_____

HAVE THERE BEEN ANY OTHER SIGNIFICANT CHANGES OR EVENTS IN YOUR CHILD'S LIFE? (FAMILY, MOVING, FIRE, DEATH OF A RELATIVE OR FRIEND)
___ YES ___ NO IF YES, DESCRIBE: _____
_____

ANY ADDITIONAL INFORMATION THAT WOULD ASSIST US IN UNDERSTANDING CURRENT CONCERNS OR PROBLEMS? _____
_____

WHAT ARE YOUR GOALS FOR YOUR CHILD'S THERAPY OR PSYCHOLOGICAL TESTING? _____
_____

WHAT FAMILY INVOLVEMENT WOULD YOU LIKE TO SEE IN THE THERAPY? _____
_____

PSYCHOLOGICAL HISTORY INITIAL INFORMATION/EVALUATION

PLEASE NOTE: WHILE INSURANCE OR ANOTHER PERSON MAY BE PAYING FOR ALL OR PART OF OUR CHARGES, OUR AGREEMENT IS WITH YOU RATHER THAN THE INSURANCE COMPANY. **YOUR SIGNATURE BELOW INDICATES YOUR UNDERSTANDING AND WILLINGNESS TO ABIDE BY OUR OFFICE POLICIES REGARDING:**

- PAYMENT OF ALL REASONABLE CHARGES INVOLVED IN THE RENDERING OF SERVICES.
- PAYMENT IS DUE AT THE TIME OF EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. PLEASE NOTE WE ACCEPT MASTERCARD, VISA, DISCOVER, AND AMERICAN EXPRESS.
- OUR FULL-SERVICE FEE IS CHARGED FOR TIME RESERVED WHEN APPOINTMENTS ARE FAILED OR CANCELLED WITHOUT SUFFICIENT NOTICE (ONE DAY.)

IF YOU BELIEVE YOUR MEDICAL INSURANCE MAY COVER THE COSTS OF ALL OR PART OF YOUR VISITS HERE, PLEASE GIVE US A COPY OF YOUR INSURANCE CARD AND COMPLETE THE FOLLOWING INFORMATION:

POLICY HOLDER	INSURANCE COMPANY OR PLAN	GROUP OR POLICY NUMBER
EMPLOYER OF POLICY HOLDER	RELATIONSHIP TO CLIENT	POLICY HOLDER DATE OF BIRTH
POLICY HOLDER'S SS#	POLICY HOLDER'S ADDRESS (IF DIFFERENT)	

WHILE WE WILL FILE YOUR INSURANCE CLAIM FOR YOU, **WE SUGGEST YOU CALL YOUR INSURANCE COMPANY** TO GET INFORMATION CONCERNING YOUR CO-PAY AND DEDUCTIBLE. WE SUGGEST YOU DO THIS BEFORE YOUR 1ST OR 2ND VISIT AND ASK THEM ABOUT YOUR COVERAGE FOR "OUT-PATIENT MENTAL HEALTH SERVICES." THIS WILL HELP YOU TO DETERMINE THE APPROPRIATE PAYMENT FOR YOUR COUNSELING SESSIONS. IN LIEU OF THIS INFORMATION, WE SUGGEST A PAYMENT OF AT LEAST 50 PERCENT OF THE INITIAL FEE FOR THE SESSION. WE WILL REIMBURSE ANY EXCESS AMOUNT ONCE YOUR INSURANCE COMPANY PAYS US. ALL CO-PAYMENTS MUST BE PAID AT THE TIME OF EACH SESSION UNLESS YOU MAKE OTHER ARRANGEMENTS WITH YOUR THERAPIST. MASTERCARD, VISA, DISCOVER AND AMERICAN EXPRESS ARE ACCEPTED. IF YOUR PLAN REQUIRES A PHYSICIAN'S REFERRAL, PLEASE CONTACT YOUR FAMILY DOCTOR BEFORE TREATMENT BEGINS.

AUTHORIZATION FOR DISCLOURE OF MENTAL HEALTH INFORMATION AND AGREEMENT

I, _____ ON MY OWN BEHALF OR AS LEGAL REPRESENTATIVE OF _____
PARENT'S NAME FOR A CHILD LESS THAN 18

AUTHORIZE THE BEING PLACE (BRENDA HENNING, M.S., LPC) AND/OR ITS REPRESENTATIVES TO RELEASE MENTAL HEALTH INFORMATION TO MY INSURANCE COMPANY TO THE FULL EXTENT SPECIFIED UNDER ANY OR ALL FEDERAL LAWS AND TEXAS STATE CODE, OR AS SUBSEQUENTLY AMENDED, TO PROVIDE UTILIZATION REVIEW OR QUALITY ASSURANCE SERVICE FO RTHE ADMINISTRATION OF CLAIMS FOR BENEFITS. I FURTHER AUTHORIZE THE BEING PLACE TO DIRECTLY RECEIVE ALL PAYMENT OF BENEFITS DUE.

THIS AUTHORIZATION ALLOWS THE BEING PLACE AND/OR ITS REPRESENTATIVES TO RELEASE INFORMATION TO MY INSURANCE COMPANY, TO ADMINISTRATE CLAIMS SUBMITTED, OR TO BE SUBMITTED FOR PAYMENT, TO CONDUCT A UTILIZAITON AND QUALITY CONTROL REVIEW OF MENTAL HEALTH CARE SERVICES PROVIDED OR PROPOSED TO BE PROVIDED, OR TO CONDUCT AN AUDIT OF CLAIMS PAID.

I ACKNOWLEDGE THAT I AM AWARE THAT I MAY INSPECT THE INFORMATION DISCLOSED AT ANT TIME, AND MAY REVOKE THIS AUTHORIZATION AT ANY TIME I FURNISH WRITTEN REVOCATION TO THE BEING PLACE AND/OR ITS REPRESENTATIVES AND, THUS, I AGREE TO ACCEPT FINANCIAL LIABILITY, FOR MENTAL HEALTH CARE SERVICES PROVIDED IF INSURANCE SHOULD DENY CLAIMS FOR BENEFITS BECAUSE OF THE INABILITY TO EXAMINE MY MENTAL HEALTH RECORDS OR THE MENTAL HEALTH RECORDS OF THE PERSON NAMED IN THIS AUTHORIZATION.

I CERTIFY THAT ALL OF THE INFORMATION IS TRUE, ACCURATE, COMPLETE AND I AGREE TO BE PERSONALLY RESPONSIBLE FOR ALL REASONABLE CHARGES NOT PAID BY MY INSURANCE COMPANY.

DATE _____ PARENT/GUARDIAN SIGNATURE _____