Child Intake Packet

- Client Information Form
- Consent to Treatment of a Child
- Parent Questionnaire
- Consent to Psychological Testing & Evaluation (if Applicable)
- Confidentiality Form
- HIPAA
- Financial Information Form

GLOBECoRe
Psychological & Global Consulting Services

Client Information Form

To assist us in providing services to you, please complete this form as fully and openly as possible. All private information is held in the strictest confidence within legal limits. **If certain questions do not apply, leave them blank**. Some of the information is required by our accrediting and licensing agencies. **If you need help completing this form, please do not hesitate to ask.** Thank you for your cooperation.

Today's Date:_____Birth Date:_____ Social Security #:_____

Name:_____ Age:_____Gender: M or F Race/Ethnicity:_____

Email Address: _____

Mailing Address: _____

Physical Address: (if different)_____

County:_____ City:_____ State:_____ Zip:_____

Do you live in a [ ] House [ ] Apartment [ ] Mobile Home [ ] Other _____

We may need to call you to remind you of an appointment or to change an appointment.

May we leave a message (*Please Circle*)? Yes No

What is the best number to leave a message and contact you?_____
Annual Household Income:_____

Who currently lives in your household?

Name	Age	Relationship	Gender

What is/are the main reason for this visit? _____
_____
_____

OCCUPATIONAL

Current means of financial support (check all that apply):

[ ] Self [ ] Family [ ] Parents [ ] Spouse [ ] Children [ ] Retirement benefits [ ] Welfare [ ] Disability

Employment Status:
[ ] employed full-time [ ] part-time [ ] unemployed [ ] disabled [ ] retired [ ] student

Current employer:_____Phone:_____

Your current position:_____Date Began:_____

YOUR CHILDREN

Name	Male/Female	Age

Who has custody of your children?_____

Are there custody issues or problems? [ ] Yes [ ] No If yes, please explain._____
_____

ABUSE HISTORY

Have you been a victim of any of the following types of abuse? If yes, please indicate by whom, the duration, and your age at the time of the abuse.

		By Whom?	Duration	Your Age
Physical Abuse	[ ] Yes [ ] No			
Sexual Abuse	[ ] Yes [ ] No			
Emotional Abuse	[ ] Yes [ ] No			
Neglect/Abandonment	[ ] Yes [ ] No			

Have you ever abused anyone? [ ] Yes [ ] No
If yes, please describe._____
_____

Have you ever been a victim of ANY other crime? [ ] Yes [ ] No
If yes, please describe._____
_____

Is there a family history of:

Substance abuse	[ ] Yes [ ] No	Describe_____
Suicide	[ ] Yes [ ] No	Describe_____
Violence	[ ] Yes [ ] No	Describe_____
Psychiatric Problems	[ ] Yes [ ] No	Describe_____
Criminal Activity	[ ] Yes [ ] No	Describe_____

SUBSTANCE USE/HABITUAL BEHAVIOR

Do you use nicotine? [ ] Yes [ ] No Type: [ ] Cigarettes [ ] Cigars [ ] Smokeless
How long have you used nicotine?_____ How much per day?_____

Do you use alcohol? [ ] Yes [ ] No
If yes, how frequent?_____
How much each time?_____

Type of use: [ ] Social [ ] Recreational [ ] Abusive [ ] Problematic [ ] Addicted

If you do not currently use alcohol have you in the past? [ ] Yes [ ] No
If yes, how frequent?_____
How much each time?_____

Type of use: [ ] Social [ ] Recreational [ ] Abusive [ ] Problematic [ ] Addicted

Do you currently or have you in the past used street drugs or abused prescription drugs? [ ] Yes [ ] No Details:_____

Do you have any other addictive or compulsive behaviors (eating, gambling, etc.)?_____
_____

MEDICAL HISTORY
Primary care physician:_____
Address:_____

Are you under the care of a psychiatrist: [ ] Yes [ ] No If so, whom:_____

Other important healthcare providers:_____

Please list any medical conditions?_____

Date of last physical:_____Hearing exam?_____ Eye Exam?_____

What kinds of physical exercise do you get?_____

Due you restrict your eating in any way, if so, how and why?_____
_____

Do you have any problems getting enough sleep, if so, what problems?_____
_____
_____
_____

HOSPITALIZATIONS (PHYSICAL OR MENTAL HEALTH)

Hospital Dates Reason

OUTPATIENT MENTAL HEALTH TREATMENT

Facility/Therapist Dates Reason

Allergies:

ALL MEDICATIONS: (prescribed, over-the-counter, vitamins, herbs)

Medication Dose Reason Prescribing Physician

RELIGIOUS/SPIRITUAL CONCERNS

What is your religious preference?

How important is spirituality/religion in your life?

Not at all				Somewhat					Extremely
1	2	3	4	5	6	7	8	9	10

Do you have any concerns related to spirituality or religion?

Is there anything else you would like the counselor to know that has not already been covered?

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Consent to Treatment
of a Child

Name of child client: _____

The therapist named below and I have discussed my child's situation. I have been informed of the risks and benefits of several different treatment choices. The treatment chosen includes these actions and methods:

_____

_____

_____

_____

These actions and methods are for the purposes of:

_____

_____

_____

_____

I have had the chance to discuss all of these issues, have had my questions answered, and believe I understand the treatment that is planned. Therefore, I agree to play an active role in this treatment as needed, and I give this therapist (or another professional, as he or she sees fit) permission to begin this treatment, as shown by my signature below.

_____ _____

Signature of parent/guardian Date

I, the therapist, have discussed the issues above with the child's parent or guardian. My observations of this per-son's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the child's treatment.

_____ _____

Signature of therapist Date

❑ Copy accepted by parent/guardian ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

PARENT QUESTIONNAIRE

--Confidential Information--

This information will be used by the psychologist as a part of a psychoeducational evaluation for your child. Your input is appreciated.

Child's Name _____ Date: _____

Birth Date _____ Age ____ Sex ____ Grade _____ School _____

Home Address _____ City _____ Zip _____

Home/Cell Phone _____ Work Phone _____

Your Name _____ Relationship to child _____

Child adopted? _____ Child in custody of _____

Foster Care_____ Caseworker_____ County_____

Is any language other than English spoken at home? _____ If yes, what language?_____

OTHER PERSON(S) IN THE HOME:

Name:	Age:	Relationship to Child:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please give a statement of your concerns and any concerns expressed by teachers or others.

_____
_____
_____

A. DEVELOPMENTAL HISTORY

I. PREGNANCY

Duration of pregnancy: _____

Medications taken during pregnancy: _____

Did any of the complications listed below occur during pregnancy?

Threatened miscarriage _____ Infection or illness _____ Toxemia/Swelling _____

Smoking during pregnancy _____ Average number of cigarettes per day: _____

Alcohol during pregnancy _____ Describe, if beyond an occasional drink: _____

_____

Drugs during pregnancy _____ Indicate specific drug and how often: _____

_____

Describe alcohol consumption or use of drugs by the father prior to conception: _____

_____

Other complications: _____

II. DELIVERY

Birth Weight: _____ lbs. _____oz. **Duration of labor:** _____ hours

Type of labor:
Spontaneous _____
Induced _____

Type of delivery:
Vertex (normal) _____
Breech _____
Cesarean _____

Forceps Used:
High _____
Mid _____
Low _____

Complications:
Cord around neck _____
Cord presented first _____
Hemorrhage _____
Infant injured _____
Other _____

Respiration:
Immediate _____
Delayed _____ If delayed, how long? _____

Cry:
Immediate _____
Delayed _____ If delayed, how long? _____

III. POST DELIVERY PERIOD (While in the hospital)

Jaundice _____ Cyanosis (Turned blue) _____ Incubator care _____ If yes, number of days: _____

Birth defects _____ If yes, specify: _____

Total number of days baby was in the hospital after the delivery: _____

Describe other problems not listed: _____

_____

IV. DEVELOPMENTAL MILESTONES

Record the age your child reached the following developmental milestones. If you cannot recall the age, check *early, normal, or late* to indicate when your child achieved each skill. Please use the provided age ranges as a guide.

	Normal Age Range	**EARLY**	**NORMAL**	**LATE**
Sat without support	*5-8 months*			
Crawled	*8-10 months*			
Stood without support	*9-12 months*			
Walked without assistance	*12-14 months*			
Spoke first words besides "ma-ma" & "da-da"	*7-12 months*			
Spoke in phrases	*1-2 years*			
Spoke in sentences	*2-3 years*			
Rode tricycle	*2-3 years*			
Bowel trained, day	*2½ -3 years*			
Bladder trained, day	*2½ -3 years*			
Bowel trained, night	*3-4 years*			
Bladder trained, night	*3-4 years*			
Buttoned clothing	*3-4 years*			
Named colors	*3-4 years*			
Said alphabet in order	*3-4 years*			
Tied shoelaces	*5-6 years*			
Began to read	*5-6 years*			
Rode bicycle without training wheels	*6-8 years*			

V. MEDICAL HISTORY

Is your child in good health? Yes _____ No _____

Please indicate if your child's history includes any of the following:

	AGE	**REMARKS** (Comment on any complications, unusual results, and/or the degree and duration of fever.)
SLEEP PROBLEMS		
EYE/VISION PROBLEMS		
FREQUENT EAR INFECTIONS		
DIABETES		
MEASLES		
SCARLET FEVER		
RHEUMATIC FEVER		
MUMPS		
PNEUMONIA		
HIGH BLOOD PRESSURE		
FREQUENT HEADACHES		
CHRONIC COLDS		
ALLERGIES		
ASTHMA		
TONSILLECTOMY		

	AGE	**REMARKS** (Comment on any complications, unusual results, and/or the degree and duration of fever.)
ADENOIDECTOMY		
BLACKOUTS		
GLANDULAR DISTURBANCES		
EXTREME FATIGUE		
SERIOUS HEAD INJURIES		
CONVULSIONS/SEIZURES		
SICKLE CELL		
OTHER		

Describe any surgery the child has had: _____

_____

Describe any other serious illnesses, accident, falls, or deformities not already mentioned: _____

_____

List any diagnoses or special services your child has received: _____

_____

_____

Medication prescribed for child:

MEDICATION:	**DOSAGE:**	**REASON/CONDITION:**	***Does the medication seem to help?***

VI. COORDINATION

Rate your child on the following skills (*Check Above Average, Average, or Below Average.*):

	ABOVE AVERAGE	**AVERAGE**	**BELOW AVERAGE**
Walking	_____	_____	_____
Running	_____	_____	_____
Throwing	_____	_____	_____
Catching	_____	_____	_____
Shoelace tying	_____	_____	_____
Buttoning	_____	_____	_____
Handwriting	_____	_____	_____
Athletic abilities	_____	_____	_____

VII. ACADEMIC

Rate your child's academic learning. (*Check Above Average, Average, or Below Average.)*

	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Preschool/PreK	_____	_____	_____
Kindergarten	_____	_____	_____
Elementary Years	_____	_____	_____
Current School Year	_____	_____	_____

Has your child had trouble with: Reading _____ Math _____ Spelling _____ Writing _____

Has your child ever been retained or had to repeat a grade? _____ If yes, which grade(s)? _____

Has your child ever received special or remedial services? _____ If yes, describe: _____

_____

Please list the schools your child has previously attended:

SCHOOL	CITY	STATE	DATES ATTENDED
1.			
2.			
3.			
4.			

B. SOCIAL HISTORY

I. CONDUCT

Rate your child's school behavior. (*Check Above Average, Average, or Below Average.*)

	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Preschool/PreK	_____	_____	_____
Kindergarten	_____	_____	_____
Elementary Years	_____	_____	_____
Current School Year	_____	_____	_____

Has your child exhibited any of the following:

	YES	NO
Lying	_____	_____
Stealing	_____	_____

	YES	NO
Discipline problems at school	_____	_____
Discipline problems at home	_____	_____
Suspended from school	_____	_____
Involved with juvenile court	_____	_____

If yes to any of the above please explain: _____

_____

How does your child get along with teachers? _____

Does he/she have unusual habits or behaviors? If yes, specify: _____

_____

Does he/she have unusual fears? If yes, specify: _____

Describe your child's self concept: _____

_____

Has your child's teacher described any of the following as significant classroom problems?

	YES	NO
Does not sit still in his/her seat	____	____
Frequently gets up and walks around the classroom	____	____
Shouts out. Does not wait to be called upon	____	____
Will not wait his/her turn	____	____
Does not cooperate well in group activities	____	____
Typically does better in one-on-one relationships	____	____
Does not respect the rights of others	____	____
Does not pay attention	____	____
Gives up easily	____	____

Describe any other classroom behavioral problems: _____

_____

II. RELATIONSHIPS WITH OTHER CHILDREN

How does your child get along with his/her siblings? Excellent _____ Good _____ Poor _____

How does your child get along with other children? Excellent _____ Good _____ Poor _____

Does your child attempt to make friends with other children? _____

Do other children attempt to make friends with your child? _____

Does your child play primarily with children his/her own age? _____Younger? _____ Older? _____

Does your child participate in:

Sports_____Clubs_____

What does he/she do for fun? _____

III. HOME BEHAVIOR

All children exhibit, to some degree, the behaviors listed below. Please rate your child's behavior when he/she is compared to other children his/her own age.

	AVERAGE	EXCESSIVE
Hyperactivity (High activity level)	_____	_____
Poor attention span	_____	_____
Impulsivity (Poor self-control)	_____	_____
Easily frustrated	_____	_____
Temper outbursts	_____	_____
Careless table manners	_____	_____
Interrupts frequently	_____	_____
Does not listen when spoken to	_____	_____
Heedless to danger (Not cautious)	_____	_____
Accident prone (Clumsy)	_____	_____
Does not learn from experience	_____	_____
Poor memory	_____	_____
More active than siblings or peers	_____	_____
Tends to worry	_____	_____
Feels sad	_____	_____

IV. FAMILY HISTORY – MOTHER

Name: _____ Current Age: _____ Age at child's birth: _____

School History: Highest grade completed: _____ Grade repeated: _____

Learning problems: _____

Behavior problems: _____

Medical problems: _____

Have any of your blood relatives (not including the child and siblings) ever had problems similar to those of your child? If so, describe: _____

_____

V. FAMILY HISTORY – FATHER

Name: _____ Current Age: _____ Age at child's birth: _____

School History: Highest grade completed: _____ Grade repeated: _____

Learning problems: _____

Behavior problems: _____

Medical problems: _____

Have any of your blood relatives (not including the child and siblings) ever had problems similar to those of your child? If so, describe: _____

_____

VI. PARENT RELATIONSHIP

Circle one: Parents are: Married Divorced Separated How long? _____

Please describe any significant changes in your family or home that may have affected your child:

_____

_____

VII. ADDITIONAL REMARKS

Please use the rest of this page to include any further information that the staff at school should know in order to help your child.

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CONFIDENTIALITY AGREEMENT

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.
Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above confidentiality agreement and understand its meaning and ramification.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

HIPAA Policy

Notice of GlobeCore Inc.'s Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment, and Health Care Operations*"
  – *Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist. Another example would be when we release your treatment plan to your insurance company and/or to your primary care physician.
  – *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about your conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority.

- *Adult and Domestic Abuse* – If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authority.

- *Health Oversight Activities* – If we are the subject of an inquiry by the Georgia Board of Psychological Examiners, we may be required to disclose protected health information regarding you in proceedings before the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If we determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.

- *Worker's Compensation* – we may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing therapists. On your request, we will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

- If we revise these policies and procedures, we will notify you by mail or on your next session.

V. Complaints

If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Kelly M. Lewis, Ph.D., Lillian Morgan-Lewis, or. SueEllen D. Hollowell, MPH., at *GlobeCore, Inc.* You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Dr. Lewis, Mrs. Morgan-Lewis, or Ms. Hollowell can provide you with the appropriate address upon request.

VI. Cancellation Policy

In the Event of an emergency, you will not be charged for session cancellation. Cancellations for any other reasons that are not received by center staff at least 24 hours prior to the scheduled session will be billed at the usual hourly rate. Your insurance company will not pay for missed appointments.

HIPAA Policy

Notice of GlobeCore Inc.'s Policies and Practices to Protect the Privacy of Your Health Information

My signature attests that I have received a copy of and read the HIPPA Policy provided to me by GlobeCore, Inc.

_____ _____

Printed Name of Client Witness

_____ _____

Signature of Client and/or Guardian Date

_____

Printed Name of Client (under 18)

_____ _____

Signature of Client (under 18) Date

Financial Information Form

I truly appreciate your choosing to come to me for psychological help. If you have health insurance, it may pay for a part of the cost of your treatment here. In order for our office to verify your insurance benefits, please complete this form. We will explain any part of this form that you do not understand.

A. Patient's name: _____ Birthdate: _____Soc. Sec. #: _____
Address: _____Home phone: _____
(If the patient is a dependent) Insured's/policy holder's name: _____
Occupation:_____Employer: _____
Work phone: _____
Address of employer:_____

B. (If applicable) Spouse's name: _____Birthdate: _____
Soc. Sec. #: _____Occupation:_____Employer: _____
Work phone: _____
Address of employer:_____

C. INSURANCE:
Primary Insurance Co: _____Insured's Name: _____
Date of Birth:_____Insured's SS#:_____
Address (Where to mail claim): _____
Phone:_____ID No. _____Group No. _____
(If applicable) Authorization #:_____

Secondary Insurance Co: _____Insured's Name: _____
Date of Birth:_____Insured's SS#:_____
Address (Where to mail claim): _____
Phone:_____ID No. _____Group No. _____

Note: We can only give you information based on what we are told by your insurance company on the day we call. Benefits are always based on your actual coverage on the date of service.

D. To Check Insurance Benefits

In order to determine if your benefits will cover your counseling and/or psychological testing services, we will be asking your insurance company the following questions:

Questions	Answers
Does this patient have benefits for outpatient behavioral health and/or psychological testing?	
Is this provider considered in or out of network? **Kelly M. Lewis, PhD**	
If out-of-network, does this patient's plan cover services with an out-of-network provider?	
What is the patient's deductible, and has it been met?	
Does the patient have a copay and/or coinsurance?	
Do any limits apply to the number of sessions that are covered?	
Are any authorizations required?	

E. If you do not have insurance, how will you pay for services from this office?

_____

F. I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

G. I understand that I am responsible for all charges, regardless of insurance coverage.

H. Assignment of benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

_____ _____

Client's (or parent/guardian's) signature, indicating agreement to all of the statements above

Date

_____

Printed Name