PRESBYTERIAN COUNSELING

Personal Information for Child & Adolescent
(Please complete all requested information on front and back of this form)

Child's Name:_____Nickname:_____Phone #:_____

Child's Address**:**_____Zip Code_____ Social Security #:_____

Birthday:_____/_____/_____ Age:_____ School:_____ Grade:_____

Name and Age of Siblings:_____

_____

What brings the child here?_____

Child's Mothers Name**:**_____Home/Work Phone:_____

May we call her?_____ When?_____ Where?_____

Employer**:**_____Social Security #____ ___ _____ Occupation**:** _____

Child's Fathers Name**:**_____Home/Work Phone:_____

May we call him?_____ When?_____ Where?_____

Employer**:**_____Social Security #:____ ___ _____ Occupation**:** _____

Are parents married, separated, divorced? **(Please circle)**

With whom does the child live at this time? Mother, Father, Both, Other **(Please circle)**

If Other: _____

If divorced, who has legal custody? Mother, Father, Joint Custody, Other **(Please circle)**
Custody Agreement papers required and both parents must sign release form for treatment.

If Other: _____

*Who is responsible for the bill? Mother, Father, Joint, Other **(Please Circle)***
Release is required from responsible party stating they are responsible for all outstanding bills not paid by the Insurance company. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service.

If Other:_____

Please list any prescription and non-prescription medications the child is currently taking**:**

_____

ANY KNOWN ALLERGIES**:**_____

List physicians child has seen within the last 24 months**:**_____

Revised 4/2018

Primary Insurance of Child/Adolescent

Release is required from policyholder to file insurance if other than parent or legal guardian

Name of Policy Holder**:**_____Relationship to child**:**_____

Insurer's Birth Date:_____/_____/_____ Social Security No:_____ _____ _____

Employer Name and Address:_____Employer's phone No:_____

Insurance Company Name & Address:_____

Policy No:_____ Group No:_____ Authorization No:_____

Secondary Insurance of Child/Adolescent

Insurer's Birthdate:_____/_____/_____ Social Security No:_____ _____ _____

Employer Name and Address:_____Employer's phone No:_____

Insurance Company Name & Address:_____

Policy No:_____ Group No:_____ Authorization No:_____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option, which you prefer. Payment in full at each appointment is required from the adult accompanying a minor (or guardian of the minor). Release is required from responsible party stating they will pay all outstanding bills not paid by insurance company if other than legal guardian. Personal Check_____, Cash_____ & Credit Card (Visa, MasterCard & Discover. As a service to you, the clinic will bill insurance companies and other third party payers, but cannot guarantee such benefits or the amounts covered, and is not the responsible for the collection of such payments. Responsible party is responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

Authorization for Insurance & Consent for Services of Minor Child/Adolescent

I, the undersigned, have insurance coverage with_____ and assign directly to Presbyterian Counseling Center all medical benefits for services rendered to my minor child/adolescent. I understand I am financially responsible for all charges whether or not paid by the insurance company. I hereby authorize Presbyterian Counseling Center to release all information necessary to secure the payment of benefits. I authorized the use of this signature on all my insurance submissions. I hereby give my consent for treatment for my child/adolescent for services to be provided by Presbyterian Counseling Center. I have read the Policies & Procedures sheet and certify that the above information in correct.

Signature of Insured:_____
Date_____

Signature of Parent or Legal Guardian:_____
Date_____

Signature of Parent:_____
Date:_____

Revised 4/2018