Patient Name: ____

Birth Date: ________________________ Age: _______ Sex: ____ M ____ F
Month/Day/Year

Preferred Language(s): ____

Mother's Name: ___________________________ Father's Name: ___________________________

Parent Status: __Married __Divorce __Single __Live Together __Other

PRIMARY ADDRESS:

____

____

____

Home Ph: (_____) ____________ msg ok ___

Cell Ph: (_____) ______________ msg ok ___

Work Ph: (_____) _____________ msg ok ___

SECONDARY ADDRESS:

____

____

____

Home Ph: (_____) ___________ msg ok ___

Cell Ph: (_____) _____________ msg ok ___

Work Ph: (_____) ____________ msg ok ___

____

RESPONSIBLE PARTY (PLEASE PRINT CLEARLY)
(If minor, parent or guardian who brings child in for appointments.)

PRIMARY INSURANCE:	SECONDARY INSURANCE:
MEMBER I.D. NUMBER:	MEMBER I.D. NUMBER:
Birthdate: / / GROUP #:	Birthdate: / / GROUP #:
Employer:	Employer:

PAYMENT INFORMATION

CREDIT CARD TYPE (please circle): VISA MASTERCARD AMERICAN EXPRESS DISCOVERY

CARD NUMBER: _______________________ EXPIRY DATE: _____/_____ CSC: ________

MEDICAL INFORMATION

Patient's physician: ____ Phone: _____________________

Medications and Dosage: ____

PSYCHOLOGICAL INFORMATION

Previous psychological evaluation and/or treatment? ____

Therapist's name: ______________________________________ **Dates?** ________________________

SCHOOL INFORMATION

School: ____ **Grade:** _________________

Teacher's Name: ____________________________________ **Spec Ed?** _____________________________

Concerns: ____

Has child undergone any psychological testing? ____

____
____

ALERT

- When two addresses are supplied, statements are mailed to each address until balance is zero.
- *I do no enter into financial disputes between households.* Ultimate payment responsibility remains with the "responsible party" – the parent/guardian who brings a child in for appointment.
- I strongly urge that you verify your mental health coverage. It varies from plan to plan and most insurance carriers require pre-authorization for mental health benefits.
- It is your responsibility to find out what pre-authorization requirements are and what is covered. You are responsible to keep your authorization status current.
- *You are responsible to submit and coordinate your claims* unless you have Premara Blue Cross. In all instances, you are responsible to contact insurance when claims are delayed.
- If you do not wish to incur any administrate fee while claims are being processed, pay in full at the time of your visit and have the insurance carrier reimburse you directly
- If you are uninsured, payment in full is expected at the time of service.
- Scheduling times are reserved for families who keep their payments current.

____
____

Signed Consent to Treatment and Terms

My signature below does NOT indicate that I am waiving *any* of my rights outlined by the Health Insurance Portability and Accountability Act (HIPPA) disclosures. My signature below DOES indicate:

- I've reviewed Dr. Clancy's intake documents and understand them to my satisfaction.
- I give permission for evaluation and treatment for myself (or my minor child).
- I give permission for as-requested claim processing information to be released to my insurance carrier.
- I understand there are certain exceptions to confidentiality rights and these have been fully explained.
- I agree to abide by the policies contained therein, scheduling, financial, and insurance terms, including:
    - ✓ Call my insurance plan regarding coverage and pre-authorization. Obtain pre-authorization.
    - ✓ Bring co-pay to each appointment (or full amount if I don't wish to incur 1% administrative fee).
    - ✓ Submit claim within 10 days of visit, coordinate delayed claims, and pay any uninsured balance.
    - ✓ Pay 1% administrative fees when balance is carried for any reason, including delayed claims.

______________________________________ ______________________________________

SIGNED BY PATIENTS 13 YRS & ABOVE ***SIGNED BY PARENTS/GUARDIANS OF MINORS***

SIGNATURE DATE: _____ / _____/ _____
M D Y

SIGNATURE DATE: _____ / _____/ _____
M D Y