Child & Teen Information Form

Office Use: ID verified: ______ Type:______ Clinician:_______

Information About Your Child

Child's Name: ____ Today's Date: ______________

Home Address: ____ _________________________, _______, _____________
Street City State Zip

Age: _______ Date of Birth: _____/_____/______ Home Phone: ___________________________________ Grade: ______________

School:____ Physician:_______________________________________

List any ongoing medical problems of your child:

List any medications your child takes on a regular basis:

List any medication allergies your child might have: ☐ none known ☐ _____________________________________

Briefly describe the main concern or question leading you to seek consultation about this child:

____

____

____

Information About Your Family

Please list each parent or guardian actively involved in this child's care. It is not necessary to repeat addresses if same as above.

Name: ____ Age: _______ Relationship: _____________________________

Address: ____ Personal Phone:_______________________

Employer: ____ Occupation: __________________________________

Work Phone: ____ If needed, may we leave messages for you at work? ☐YES ☐NO

____

Name: ____ Age: _______ Relationship: _____________________________

Address: ____ Personal Phone:_______________________

Employer: ____ Occupation: __________________________________

Work Phone: ____ If needed, may we leave messages for you at work? ☐YES ☐NO

E-mail of primary contact person: ______________________________________@_______________________________ . ________

Providing your e-mail is optional, but important to allow access to our secure client portal system to share materials and documents. Directly e-mailing your clinician is not be considered confidential, and doing so assumes you understand and accept the risks to your privacy.

____

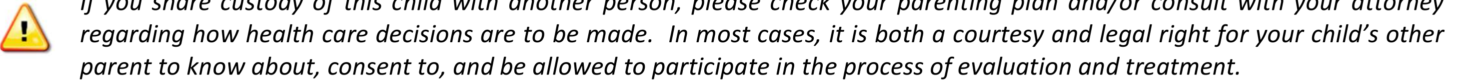
Do you share custody/guardianship with another person not listed above (e.g., an ex-partner, etc.)? ☐YES ☐NO

If yes, does this person know about and consent to you bringing your child for these services? ☐YES ☐NO

If applicable, please provide contact information for any legal guardian of this child not listed previously:

Name: ______________________________ Relationship to child: ______________________

Address: ______________________________________ Contact Phone:__________________



If you share custody of this child with another person, please check your parenting plan and/or consult with your attorney regarding how health care decisions are to be made. In most cases, it is both a courtesy and legal right for your child's other parent to know about, consent to, and be allowed to participate in the process of evaluation and treatment.

Other people living in the home:

Name	*Age*	*Relationship*

Who referred you to our office?____

It is customary to send a note of thanks to referring professionals. May we do this in your case? ☐YES ☐NO ☐ N/A

Emergency Contact Person: ____________________________ Phone # (________) _________-_______________

Your clinician wants to ensure that he or she is providing the best care possible based on your child's particular culture and language preference. Please complete the following information about your child: (check one)

☐ Native American/Alaska Native ☐ Asian ☐ White/Caucasian ☐ Black/African American

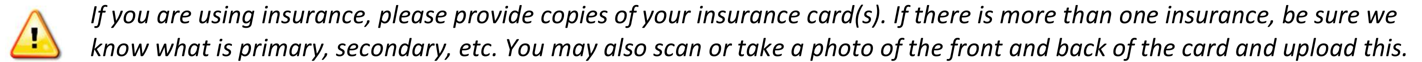
☐ Native Hawaiian/Pacific Islander ☐ More than one race Is this child Hispanic or Latino? ☐ Yes ☐ No

Does this child prefer to communicate in a language other than English? ☐ Yes ☐ No - If yes, which?_______________________

Billing and Insurance Information

How do you prefer to cover your child's expenses?

☐ Cash ☐ Insurance ☐ Employee Assistance ☐ DSHS/CPS ☐ Attorney ☐ Other________________________



If you are using insurance, please provide copies of your insurance card(s). If there is more than one insurance, be sure we know what is primary, secondary, etc. You may also scan or take a photo of the front and back of the card and upload this.

Name of **Primary** Insurance Carrier: ____

Name of Insurance Subscriber:______________________________ Subscriber's Birthdate:___________________

Subscriber's Employer: ______________________________ Policy Number:__________________________

Name of **Secondary** Insurance Carrier: ____

Name of Insurance Subscriber:______________________________ ___Subscriber's Birthdate:____________________

Subscriber's Employer: ______________________________ Policy Number:__________________________

Even if you are using insurance or expect your child's services to be paid by someone else, please provide the name of the parent or guardian who is financially responsible for this child:

____

Required: Social Security Number of the financially responsible person: __________--_________--_______________

***Why we need your Social Security Number* (SSN)**: If you are not paying cash in full, your clinician becomes a business offering you credit and carrying outstanding balances on your behalf. This allows correct identification of the person responsible for this account. Your SSN is kept secure in the child's file, and is required even if you have insurance and/or do not expect to have any co-pays. Not providing this number assumes you are planning to pay cash in full at time of each service.

Authorizations and Signatures --------- Please read and sign the following

⚠ *The person signing this form must have legal authority to do so. In most cases, this will be the child's custodial parent and legal guardian, or another court-appointed party.*

I am requesting psychological services on behalf of my child. I have been provided information regarding office policies, including fees, missed appointments or late cancellations, the right to refuse treatment, choosing the best treatment provider, extent of confidentiality, protecting my child's health care record, and information about my child's clinician. I understand I am a private client of my clinician, not of NWPR or any other NWPR-affiliated clinician.

____ ______________________________________

Signature Date

If you plan to use insurance benefits to help cover evaluation and treatment costs, you will need to allow us to communicate with your insurer. Your signature below will allow us to bill your insurance company and to collect payment from them directly. Please review the following and sign below. Ask us if you have any questions.

My signature below allows: (1) NWPR to release basic, confidential information about my child, such as date and type of service, diagnosis, and other information required to process insurance claims; (2) My insurance company to pay benefits directly to NWPR to be applied to my child's account; and (3) NWPR to bill my insurance company in the future without me having to sign for this each time. I understand that I am responsible for any charges not covered or reimbursed by my insurer. This authorization is valid until withdrawn by me in writing. I may revoke this release at any time except to the extent that action has already been taken in reliance on my consent.

____ ______________________________________

Signature Date

Thank you!

I look forward to being of service to you and your family.

For more information, please visit our websites at: www.nwpsych.com

Office Policies, Informed Consent for Treatment, and Protecting the Privacy of Your Health Record

Signature Page

Included with this intake information is a form entitled **Office Policies, Informed Consent for Treatment, and Protecting the Privacy of Your Health Record**. Let us know if you did not get this document.

Please look over this information and important policies. Take this document home with you. However, governmental regulations require that we verify you received this material.

Please print and sign your name below. Your clinician will sign their name and keep this page in your file.

I certify that I have received a copy of "Office Policies, Informed Consent for Treatment, and Protecting the Privacy of Your Health Record."

____

Printed Name of Patient or Legal Guardian

____ ________________

Signature of Patient or Legal Guardian Date

____ ________________

Signature of Clinician Date

Debit/Credit Card and HSA Guarantee Form

We strongly encourage you to allow us to maintain a debit/credit or Health Savings Account card on file in our secure billing system. This will allow us to 1) automatically collect co-payments without you having to come to the front window each visit, 2) easily and quickly clear balances owed after insurance has paid without you have to come in or mail checks to our office, and 3) avoid potential problems with overdue accounts.

I understand my credit card number will be kept confidential and securely on file with NWPR. I authorize billing my credit card under the one or both of the following conditions:

Please initial one or both options:

________ I specifically ask that my visit co-payment or some or all of my personal balance be charged to my card as an alternative to writing a check or paying cash at the time of service, or as an alternative to me mailing or bringing in payment.

________ If I have an outstanding balance more than 60 days past due and I have not already agreed with my clinician upon a plan of payment, then I allow my card to automatically be charged for the balance due to clear my account to avoid interest, late payment fees, or collection actions.

Card Information

Type	***Card Number***	***CCV Code***
□ Visa □ Mastercard □ Other ____________	____________ - ____________- ____________-____________	____ ____ ____ 3 digit code on back
Name as it appears on card *(please print clearly)*		***Expiration Date*** _______ / __________ Month Year

I hereby authorize Northwest Psychological Resources to charge the balance of my account for any fees not paid at the time of service under the conditions described above. I also agree to inform NWPR and provide updated information if this card is terminated, expires, or changes in any way.

____ _____________________

Signature of Patient or Financially Responsible Guardian Date

OFFICE USE ONLY		
Clinician Last Name	Client Name	
Client Mailing Address ____ _______________________________ , __________ ___________________________		Amount charged: [ ] Co-payment only [ ] Current client balance due [ ] Other:_________________
Notes:		