COMMUNITY PSYCHOLOGICAL CONSULTANTS
9102 North Meridian Street, Suite 400
Indianapolis, IN 46260
(317) 574-1785
Fax: (317) 574-1786

CHILD PATIENT REGISTRATION FORM
Date_____
Provider's Name_____
New _____ **Change** _____

Please print and answer all questions. Thank you.

Child's Name _____ Male__ Female__

Address_____

City, State, Zip Code_____

Home Phone_____Work Phone_____Cell Phone_____Self, Mother's, Father's

Age____ Birth Date _____ Grade_____ School_____

Mother's Name_____Father's Name_____

Social Security # (mother)_____ Social Security # (father)_____

Address of either parent if different from child_____

Siblings (names and ages)_____

_____

General Medical Condition_____ Physician _____

Current Medications (Names and Dosage)_____

_____

Referral Source_____

Previous Counseling_____

Presenting Problems_____

_____

Marital Status of: Mother_____ Father_____

Mother's Occupation _____ Father's Occupation_____

Parents' Education or Highest Grades Completed_____

Name of person we may contact in case of an emergency_____

Relationship to Child_____ Phone #_____

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__Jacqueline L. Hess, Psy.D., HSPP
__Bryn Dungan, Psy.D., HSPP
__Katherine D. Glaser, MSW.,LCSW
__Rachel Feldwisch, Ph.D., MA, LMHC, ATR-BC
__Daniel H. Stauber, M.A., LCSW
__Jennifer L. Godar, Psy.D., HSPP
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An Association of Independent Mental Health Providers

Request for Confidential Handling of Health Information

_____ _____ request that the practitioner
Patient's Name *Patient's Date of Birth*

checked above handle the confidential health information in the following way: (Please check all the way (s) we may contact you).

_____U.S. Mail _____ Home telephone

_____ Business telephone _____ Cellular phone

_____ Fax _____Email_____

_____ Other_____

Please complete the following section only if you want communication regarding your health care Information sent to an alternate address (other than your residence). All reasonable request to receive communication of your health information at alternative locations will be granted

_____
Street Address City State Zip code

Referring physician: _____

Phone: _____Fax: _____

Address _____

May we contact this physician to coordinate care? Yes_____ No_____

_____ _____
Signature of patient/parent/legal guardian Date

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ASSIGNMENT OF BENEFITS AND INDIANA MENTAL HEALTH PROFESSIONAL-PATIENT AGREEMENT

I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered. _____
Initial

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that if collection proceedings are necessary, I will pay all fees with collecting this bill. _____
Initial

I have received/read the mental health profession-patient services agreement and agree to its terms and also I have received the HIPAA information contained therein. _____
Initial

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. NO-SHOW OR CANCELLATIONS WITHIN 24-HOURS OF APPOINTMENT TIME MAY RESULT IN A SELF-PAY CHARGE.

_____ _____
Patient's Name Patient's Date of Birth

_____
Signature of Patient/Parent/Legal Guardian

_____ _____
Date Printed Name of Patient/Parent/Legal Guardian

PATIENTS WITH MEDICARE COVERAGE

I request that payment of authorized Medicare benefits be made to Community Psychological Consultants for services provided. I authorize the release of information regarding my treatment to the Health Care Financing Administration for determination of benefits for services provided.

_____ _____
Date Signature of Patient/Parent/Legal Guardian

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Dear Client/Responsible Party on Behalf of Client:

We attempt to verify your benefit coverage for our services to the best of our ability by contacting your insurance company, _____. We need to inform you; however, that benefit coverage does not guarantee payment by your insurance company. If coverage is denied by your insurance company, you will be personally responsible for all charges incurred by signing and dating this form.

_____ _____
Client Name Witness Name

_____ _____ _____
Printed Name of Responsible Party Printed Witness Signature DATE

_____ _____
Signature of Responsible Party DATE