COMMUNITY PSYCHOLOGICAL CONSULTANTS
11350 N. Meridian Street, Suite 300
Carmel, Indiana 46032
An Association of Independent Health Practitioners
P. (317) 574-1785 Fax: (317) 574-1786

CHILD REGISTRATION FORM

Please print and answer all questions. Thank you.

Provider: Mary L. Sanders, Ph.D., HSPP ____ Daniel Stauber, M.A., LCSW ____

Name of Person Completing Form ________________________ **Date** _____________

Child's Name ____

Address ____

____
City State Zip Code

Age______________ **Birth Date** ______________________ **Male or Female (circle)**

Grade_________**School**____

Presenting Concerns

____

____

____

____

Mother's Name____

Father's Name____

Address of either parent if different from child _______________________________

____

Custody/Parenting Time Arrangements _____________________________________

____

Siblings (names. date of birth, relationship, residence)

____

____

____

____

____

____

____

General Medical Condition________________ **Physician** _________________________

Physician Contact Information: ____

Current Medications (Name/Dosage/Reason for Medication) ____________________

____

____

____

Who Referred Your Child? ____

Previous Counseling ____

____

Previous Evaluations ____

____

Marital Status of: Mother__________________ Father______________________________

Mother's Occupation ________________ **Father's Occupation**_____________________

Parents' Education or Highest Grades Completed _______________________________

Emergency Contact (Name, Relationship to Child, Phone #) ______________________

____

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Request for Confidential Handling of Health Information

____ Mary L. Sanders, Ph.D., HSPP ____ Daniel Stauber, M.A., LCSW

I, ____,
Parent, Guardian, or Responsible Party Name
give permission to the above provider to contact me or to otherwise transmit confidential health information regarding services for ____.
Child's Name
Please check all that apply and provide the relevant information:
.
____ U.S. Mail ____

____ Email ____

____ Home Telephone __________________________________

____ Business Telephone _______________________________

____ Cellular Phone ____________________________________

____ Fax ____

____ 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).

____
Street Address City State Zip code

Referring physician/other: ____

Phone: _______________ Fax: ______________

Address: ____

Do I have permission to contact your physician to coordinate care? Yes_____ No______

____
Signature of Patient/Legal Guardian Date

Dr. Sanders does not directly bill insurance for her services. She will, at your request, provide you with a superbill that you can submit to your insurance company for possible out-of-network insurance reimbursement.

Mr. Stauber is an in-network provider for some insurance companies. If you are planning to use insurance, please complete the following:

Client Name/Birthdate: ____

Insured's Name/Birthdate: ____

Primary Insurance: __________________________ Insured's Employer: ______________

Member ID: ___________________________ Group ID: ___________________________

Insurance Phone Number: ______________________ Effective Dare: ________________

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 made within twenty-four hours of a scheduled appointment may result in an An Out-of-Pocket Charge.

____ ________
Client's Name Date of Birth

____
Signature of Client/Parent/Guardian Date