

PATIENT INFORMATION (MINOR OR DEPENDENT CHILD)

Please Print Clearly

PATIENT'S NAME _____ DOB _____ AGE _____ SEX _____

ADDRESS _____

CITY & STATE _____

GRADE IN SCHOOL _____ NAME OF SCHOOL _____ DISTRICT _____

LEGAL GUARDIAN(S): Father _____ Mother _____

FATHER'S OCCUPATION _____ EMPLOYED BY _____

HOME PHONE _____ WORK PHONE _____

FATHER'S SOCIAL SECURITY # _____ DRIVERS LICENSE# _____

MOTHER'S OCCUPATION _____ EMPLOYED BY _____

HOME PHONE _____ WORK PHONE _____

MOTHER'S SOCIAL SECURITY # _____ DRIVERS LICENSE# _____

REFERRED BY _____ MEDICAL INSURANCE: YES NO

INSURANCE CO #1 _____ INSURED'S NAME _____

I.D. # _____ GROUP # _____ INSURED'S SS# _____

INSURANCE CO #2 _____ INSURED'S NAME _____

I.D. # _____ GROUP # _____ INSURED'S SS# _____

PERSON TO CONTACT IN EMERGENCY _____

ADDRESS _____ PHONE _____

(See Other Side)

CONSENT FOR TREATMENT OF MINOR CHILD

Re: _____ Birthdate: _____
Last Name First Middle

I certify that I am the {father, mother, managing conservator, legal guardian (circle one)} of the above named child, and I hereby give my authorization and informed consent for the above named child to receive psychological or therapeutic outpatient diagnostic and treatment services from the staff of Professional Psychological Services, PC. I further certify that I have the legal authority to authorize and consent to this treatment.

DATE

LEGALLY AUTHORIZED SIGNATURE

PRINTED NAME

STREET ADDRESS

CITY STATE ZIP

If you wish Professional Psychological Services to file for direct reimbursement by your insurance company, please provide information requested below. Your signature will be your authorization to Professional Psychological Services to charge your credit account for any outstanding balance that exceeds ninety days. You will be notified of any charge made to your account. If your account should be overpaid you will be informed and a reimbursement will be made to you at your request.

CREDIT LINE: **MasterCard Visa American Express Discover**

Account Number: _____

Card Expiration Date: _____

Name Appearing on Account: _____

Signature: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign payment of medical benefits by _____ insurance company to Professional Psychological Services, P.C. I also authorize the release of any medical information requested by the above named insurance company. The assignment will remain in effect until revoked by me in writing, a photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Date

Signature