REGISTRATION
(PLEASE PRINT)

PHILMORE ASSOCIATES

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

Philmore Associates, LLC

Payment Policy

We are dedicated to providing the best possible care for you and want you to completely understand our financial policies. By signing the patient registration form, you are acknowledging that you have read, understand, and agree to Philmore Associates, LLC financial payment policy.

Patient Responsibility:

- Keep in mind that your insurance policy represents a contract between you and your insurance company. As a courtesy to you, we will file your insurance claim for you. If payment is not received from your insurance company with 14 days, we may have to look to you for payment.

- Not all insurance plans cover all services. In the event your insurance plan determines a service is "not covered" or if you are not covered by an insurance plan you will be responsible for the full charge. Payment will be due at point of service.

- If you are insured by an insurance plan that our providers do not participate with or if you do not have insurance, you must pay for services prior to your visit or make payment arrangements with the office.

- Philmore Associates will only bill your primary and secondary insurance carrier. If you would like a third party billed, you will be responsible for doing so.

- Payment is due at the time of service. We accept payments in the form of cash, checks or credits cards. Please note that a 4% credit card processing fee will be added to your charge – this is the fee charged to the Philmore Associates by the credit card companies. A $35 returned check fee will be charged for checks returned due to insufficient funds. Failure to make payment at the time of your visit will result in a $10 administrative fee for each missed payment.

- If you schedule an appointment with our office and you are unable to keep your appointment, we kindly ask that you to notify us 24 hours in advance to avoid a $50 FEE.

- There will be a fee for letters and/or reports written on your behalf by our providers. The fee schedule will be discussed on a case by case basis as there may be specific requirements impacting the amount of time required for preparation and dissemination.

THE PHILMORE ASSOCIATES

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made.

I accept full responsibility for all charges for services provided to me, to my minor/child, or to the patient for whom I have legal responsibility.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Patient, Parent, Guardian or Legal Representative Print Name

Witness Date

One Franklin Avenue • PO Box 599 • Nutley, NJ 07110
Phone 973.667.6074 • Fax 973.751.1626

CHILD HISTORY FORM

Child's Name:_____ Date of Birth:_____ Age:_____ Sex: F M

Child's Address_____ School/Grade:_____

City, State, Zip:_____ Name of person who referred you:_____

Home Phone:_____ Name of person completing this form:_____

Parents' names:_____ Today's date:_____

1. PLEASE DESCRIBE YOUR CHILD'S CURRENT DIFFICULTIES: *(Use additional pages if necessary).*

_____

_____

_____

_____

_____

_____

_____

When did these difficulties begin?_____

2. CHILD'S PAST BEHAVIORAL/EMOTIONAL HISTORY: *If yes, please describe:*

__ (1) Worry/Panic __ (5) ADHD _____

__ (2) Obsessions/Compulsions __ (6) Noncompliance _____

__ (3) Tics __ (7) Anger/Aggression _____

__ (4) Depression/Mood swings __ (8) Alcohol/Drug Use _____

Outpatient Therapy: __ (1) No __ (2) Yes *If yes:*

Therapist:_____ **Psychiatrist:**_____

Address:_____ Address:_____

_____ _____

Phone_____ Phone:_____

Treated for:_____ Treated for:_____

When treated:_____ When treated:_____

Therapist:_____ **Psychiatric Medications:** ___No _____Yes. *If yes:*

Address:_____ Name/Dosage Dates started/ended

_____ _____ _____

Phone:_____ _____ _____

Treated for:_____ _____ _____

_____ _____ _____

When treated:_____ _____ _____

INPATIENT PSYCHIATRIC TREATMENT __ (1) No __ (2) Yes *If yes*:

Hospital:_____

Treated for:_____

Dates Hospitalized:_____

Diagnoses:_____

3. STRESSFUL CIRCUMSTANCES:

Did your child (and you) experience any stress **recently** and during your child's **lifetime**? *(Examples: conflict with family/friend, financial problems, death, divorce, illness)* __ (1) No __ (2) Yes. *If yes, please explain when and what.*

_____

_____

_____

_____

_____

_____

Is child adopted? __ (1) No __ (2) Yes If yes, how old was child when he/she started living with adoptive parents? _____

4. PREGNANCY:

Was pregnancy planned? __ (1) No __ (2) Yes

Any problems? __ (1) No __ (2) Yes

Alcohol Use? __ (1) No __ (2) Yes

Drug Use? __ (1) No __ (2) Yes

Please describe any problems:_____

_____

5. DELIVERY:

__ (1) Premature __(2) Full Term __ (3) Post-term

__(1) Spontaneous, normal __(2) Induced

__ (3) Forceps __ (4) Cesarean

Problems after delivery? __(1) No __ (2) Yes *If yes, please describe*:_____

_____

6. MILESTONES

When did your child:	AGE	Early	Normal	Late
Sit without help	____	( )	( )	( )
Crawl	____	( )	( )	( )
Walk without help	____	( )	( )	( )
Ride bicycle	____	( )	( )	( )
Say first words	____	( )	( )	( )
Say first phrases	____	( )	( )	( )
Speak simple sentences	____	( )	( )	( )
Began to read	____	( )	( )	( )
Learn bladder control	____	( )	( )	( )
Learn bowel control	____	( )	( )	( )
Stop bedwetting	____	( )	( )	( )

7. TEMPERAMENT/PERSONALITY:

(as a baby and young child)

__ (1) Excellent __ (3) Fair

__ (2) Good __ (4) Poor

Please explain:_____

_____

_____

_____

_____

_____

_____

_____

_____

8. CHILD'S MEDICAL HISTORY: Pediatrician:_____

Address:_____ Phone:_____

Major Illness: ___ None

__ Meningitis/Encephalitis

__ Febrile seizures (with fever)

Accidents/Injuries: ___ None

__ Head Injury

__ Fractures/Broken Bones

__ Loss of Consciousness

Neurologic Condition: __ None

__ Epilepsy/Seizures

Allergies/adverse drug reactions: ___None

_____

Chronic Illness: __ None

__ Asthma

__ Diabetes

__ Renal Failure

__ Anemia

__ Handicapping condition:

Other:

__ Strep infections

__ Chronic ear infections

__ Allergies

__ Any other medical problems?

If yes to any of above, please describe:_____

_____

_____

Hospitalizations: __ (1) No __ (2) Yes *If yes*:

Hospital:_____

Treated for:_____

Dates Hospitalized:_____

Diagnoses:_____

_____

_____

Current medications (other than routine antibiotics):

__ (1) None __ (2) Yes. *If yes:*

Name/Dose	Reason
_____	_____
_____	_____
_____	_____
_____	_____

9. EDUCATIONAL HISTORY: Teacher:_____ Counselor:_____

School Address:_____ Phone:_____

EDUCATIONAL CLASSIFICATION: No ___ Yes _____

SPECIAL CLASS PLACEMENT: No _____ Yes _____

CURRENT SUPPORT SERVICES : ___ None ___ Speech therapy ___ Physical therapy ___ Occupational therapy

___ Resource room ___ Counseling ___ Other (describe): _____

TESTING (Educational/Psychological/Speech-Language): __ (1) No __ (2) Yes *Please give dates and results below.*

_____

_____

_____

_____

_____

_____

_____

ANY PROBLEMS IN SCHOOL WITH: *If yes, please describe:*

Refusal/Absence__ (1) No __ (2) Yes _____

Grades __ (1) No __ (2) Yes _____

Learning __ (1) No __ (2) Yes _____

Peer Relations __ (1) No __ (2) Yes _____

Behavior __ (1) No __ (2) Yes _____

Suspensions __ (1) No __ (2) Yes _____

10. PERSONS IN CHILD'S FAMILY *(include parents, siblings (with ages) and other persons in the household):*

NAME	RELATIONSHIP	EDUCATION	OCCUPATION

Parents' marital status: _____Married _____Separated _____Divorced _____Remarried _____Single

11. FAMILY HISTORY: Has any family member had any of the following? If yes, who, when and how treated?

Anxiety/Panic _____

OCD_____

Depression/mood swings _____

Tics/ADHD_____

Substance abuse _____

Anger/aggression _____

Schizophrenia _____

Suicidal Behavior_____

Other conditions? _____

12. FAMILY MEDICAL HISTORY: Any major illness in a family member? *If yes, please describe illness and dates:*

Child's Father:_____

Child's Mother:_____

Grandparents:_____

_____

Brother/Sister:_____

Other Relatives:_____

_____

Contractual Agreement

I have contracted with the Philmore Associates for the purpose of counseling for my child. It has been explained to me that the therapist, in order to maintain objectivity, will not offer testimony, either orally or in writing as to any legal and/or custody issues. I am in agreement with these provisions and hereby give permission for my child to receive counseling services at the Philmore Associates.

_____

print name

_____

signature date