# Child & Family Consultants, Inc.

## REGISTRATION FORM

### Client Info

| Last Name | First Name | Middle | Grade in School |
|---|---|---|---|
| | | | |
| Date of Birth | Sex | Home Phone | School Name |
| | | | |
| Street Address | City | State | Zip Code |
| | | | |
| Primary Care Physician | | Phone | |

### Payment Info

| Primary Insurance Co or Person Responsible | | Policy Number | Group Number |
|---|---|---|---|
| | | | |
| Claims Address | City | State | Zip Code |
| | | | |
| Policyholder | | Date of Birth | |
| | | | |
| Claims Phone Number | | Relationship to Client | |
| | | | |
| Secondary Insurance (if applicable) | | Policy Number | Group Number |
| | | | |
| Claims Address | City | State | Zip Code |
| | | | |
| Policyholder | | Date of Birth | |
| | | | |
| Claims Phone Number | | Relationship to Client | |

### Contact Info

| Name of Parent with Child today | Address (if different) |
|---|---|
| | |
| Contact Numbers (Please list numbers we may contact you and leave messages-if necessary) | |
| | |
| E-Mail Address (for appointment reminders and general info) | |
| | |
| Name of Other Parent or Guardian | Address (if different) |
| | |
| Contact Numbers (Please list numbers we may contact you and leave messages-if necessary) | |
| | |
| E-Mail Address | |
| | |
| Emergency Contact | Relationship to Child | Contact Number |
| | | |

Please read and sign on back.

Thank you for choosing Child and Family Consultants, Inc as your health care provider. We are committed to providing you with the best possible care. The information below is offered to help you understand our policies and responsibilities.

Please refer to the "Notice of Privacy Practices" available in the lobby. It details how we handle your Protected Health Information as required by the HIPAA legislation effective August 1, 2003. Your signature below signifies you acknowledge a copy is available to you.

**Please be advised:** you will need to provide us with written authorization if anyone, other than persons listed under "Contact Info", is here to pick up your child.

**Missed Appointments:** There is no charge for appointments cancelled 24 hours or more in advance. The office has an answering machine to receive messages after normal business hours. **The charge for missed appointments or late cancellations (other than an emergency) is $30.00.** Insurance does not cover this charge.

**Payment is due** at the time service is rendered. We accept cash, MasterCard, VISA, and personal checks **(returned checks will be charged a $25 fee)**.

**Medicaid:** A Physician's order and Medicaid Authorization must be obtained before therapy can start. Any changes to your Medicaid benefits will probably change your account to a self-pay status. Please notify us of any changes immediately.

**Insurance:** your insurance policy is a contract between you and your insurance company. We will contact them to assist in predetermining benefits. However, the information provided to us is not a guarantee of payment or authorization of service – it is a summary of plan benefits.

Even though you have insurance, you are still responsible for payment in that you must make every effort to keep up with the requirements of your insurance contract to ensure that we receive payment for the services we provide.

When or if you reach your maximum coverage on the policy for our services, the account will revert to a self-pay status until such time that your benefits are refreshed for a new year or you have made arrangements to extend your coverage for our services for the current span of time. You must inform us of ANY changes to your insurance information so coverage and benefits can be determined.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask.

**Release of Information:** I hereby authorize the use and/or disclosure of my Protected health Information concerning diagnosis and/or treatment when requested by a party for its use in determining a claim for payment for that treatment and/or diagnosis. I permit a copy of this authorization to be used in place of the original, which is on file at Child and Family Consultants, Inc. This authorization will remain in effect until revoked by me in writing.

I hereby authorize my insurance benefits to be paid directly to Child and Family Consultants, Inc for any services they provide. I understand that I am financially responsible for any and all charges related to non-covered services. If it becomes necessary to collect any sum due by contacting an attorney or collection agency, then the patient agrees to pay the costs of collection, including but not limited to attorney's fees, whether suit is filed or not.

I have read the information above and agree with the terms and conditions.

Responsible Party Signature _____ Date_____

Responsible Party Print _____ Client Name Print _____