Robyn Macfarlane, MA, LPC, PLLC
10720 Carmel Commons Blvd., Suite 330
Charlotte, NC 28226
(704) 612-4141

CLIENT INFORMATION FORM for MINORS

Today's Date: _____

Minor's Name: _____

DOB: _____/_____/_____ Age: _____ Current grade in school: _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

School currently enrolled: _____

Mother's Name:_____ Date of Birth _____

Address_____ City _____ State _____

Zip: _____ Home phone: _____ Cell Phone: _____

Email address for appointment reminders: _____

Father's name _____Date of Birth_____

Address_____ City _____State _____

Zip _____ Home Phone: _____ Cell Phone: _____

<u>Emergency Contact</u>

Name: _____

Address: _____

Phone Number: _____

INSURANCE AUTHORIZATION OF BENEFITS

Insurance Company for Mental Health Benefits: *(very important-often a different company)*

Name of Insurance Company: _____

Address of Insurance Company: _____

Phone Number of Insurance Company: _____

Subscriber Name (Policy Holder): _____

Subscriber Date of Birth: _____
(For insurance purposes only)

Policy Holder's Relationship to Client: Mother Father Guardian Other_____

Policy Number: _____Group ID #: _____

Effective Date: _____ Subscriber's Employer: _____

Please attach copy of insurance card (front & back)

I authorize Robyn Macfarlane to release any necessary information acquired in the course of my treatment to process insurance claims and to submit claims for payment of medical benefits to Robyn Macfarlane, MA, LPC, PLLC. Robyn Macfarlane will file my claim for me, and re-file if necessary, but will not assume responsibility for collecting on my insurance claim or negotiating settlement on a disputed claim. **If my insurance does not pay my claim, I understand that it will be my responsibility to pay any non-covered services.**

Signature of parent: _____ Date _____

CANCELLATION/MISSED APPOINTMENT POLICY

In scheduling an appointment, you are reserving that time slot for your therapy. If you are unable to attend your session you must provide a 24 business hours notice. Missed or cancelled appointments will incur a $75 fee unless 24 business hours notice is given. Insurance companies will not pay for missed appointments or late cancellations.

Your signature below represents your understanding and agreement to this policy.

_____ _____
Signature of Parent Date

TREATMENT INFORMATION

Please describe briefly what has led you to seek counseling:

_____

_____

_____

_____

_____

Please list medications (if applicable): _____

History of any mental health medications? Yes No

If yes, please list medications_____

History of counseling/treatment in past? Yes No

History of mental health hospitalizations? Yes No If yes, when & where? _____

_____

History or current suicidal ideation? _____

Who currently resides in the home with the minor (including any siblings)? _____

_____