

Minor Registration and Informed Consent

GENERAL INFORMATION

Date: _____

Minor's Full Name: _____
(first) (middle) (last)

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: ____ / ____ / ____ Age: ____

CONTACT INFORMATION

Phone Numbers	May we contact you at this number?		May we leave a message at this number?	
	Yes	No	Yes	No
Mother's Home				
Mother's Cell				
Father's Home				
Father's Cell				
Other				

CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS & OTHER HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications or information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

School: _____ Phone Number: _____

Teacher's Name: _____ Teacher's E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

HOUSEHOLD & FAMILY INFORMATION

Mother's Name: _____ Does this person have legal & physical custody? _____

Address: _____ City: _____ State: _____ Zip: _____

Stepfather's Name: _____ Telephone Number _____
(if applicable) (if different than above)

Father's Name: _____ Does this person have legal & physical custody? _____

Address: _____ City: _____ State: _____ Zip: _____

Stepmother's Name: _____ Telephone Number _____
(if applicable) (if different than above)

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REFERRAL SOURCE

Referred By: _____

- Website
- Facebook
- Friend
- Family Member
- Friend of the Court

Relationship: _____

- Physician
- Clergy/Church
- School
- Other Mental Health Agency/Therapist
- Attorney/Law Enforcement

FINANCIAL RESPONSIBILITIES

Person Responsible for Payment: _____

Address: _____ City: _____ State: _____ Zip: _____

I do not have insurance, and/or I decline to utilize or to have my insurance billed. By initialing this statement, I understand I am responsible for the full payment for services rendered.

Please initial

Copay Amount: \$ _____

Deductible Amount: \$ _____

Name of Insured: _____

ID # _____

Insurance Company: _____

Insured's Date of Birth _____

Secondary Insurance: _____

Contract # _____

Group # _____

SS# _____

FEE SCHEDULE

The initial assessment session is \$190 and will last approximately 1½ hours. Additional sessions are \$170 per 53 minute session. Fees may also vary depending on your circumstances and the nature of services. If it is unclear as to what your fee is, you are encouraged to discuss this with me. No shows or late cancellations (less than 24 hours) will be assessed a fee of \$40.

BILLING POLICY

1. I authorize use of this form on all insurance submissions.
2. I authorize the release of information to my insurance company.
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I understand I will be charged an extra fee for processing checks returned for insufficient funds.
5. I agree to pay the fee for each service, including co-pays and deductibles, at the time services are rendered.
6. I permit a copy of this form to be used in place of the original.
7. I agree to pay a \$40 service charge for late cancellations and for missed appointments.
8. I have been offered a HIPAA Notice, Professional Disclosure, Fee Schedule, and Limitation on Patient Confidentiality documents.
9. I have been offered a signed copy of this agreement.
10. My signature on this form authorizes my consent to treatment for my minor child.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

SIGNATURE OF MINOR CLIENT: _____ DATE: _____

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CHILD BEHAVIOR CHECKLIST FOR AGES 4-16

For office use only
ID #

CHILD'S NAME			PARENT'S TYPE OF WORK <i>(Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant, even if parent does not live with child.)</i>			
SEX <input type="checkbox"/> Boy <input type="checkbox"/> Girl	AGE	ETHNIC GROUP OR RACE	FATHER'S TYPE OF WORK: _____			
TODAY'S DATE		MOTHER'S TYPE OF WORK: _____				
Mo. _____ Day _____ Yr. _____		THIS FORM FILLED OUT BY:				
CHILD'S BIRTHDATE		<input type="checkbox"/> Mother (name): _____				
Mo. _____ Day _____ Yr. _____		<input type="checkbox"/> Father (name): _____				
GRADE IN SCHOOL		<input type="checkbox"/> Other—name & relationship to child: _____				

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc. <input type="checkbox"/> None	Compared to other children of the same age, about how much time does he/she spend in each?	Compared to other children of the same age, how well does he/she do each one?																
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II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, singing, etc. (Do not include T.V.) <input type="checkbox"/> None	Compared to other children of the same age, about how much time does he/she spend in each?	Compared to other children of the same age, how well does he/she do each one?																
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III. Please list any organizations, clubs, teams, or groups your child belongs to. <input type="checkbox"/> None	Compared to other children of the same age, how active is he/she in each?									
a. _____	<table style="width: 100%; text-align: center;"> <tr> <td>Don't Know</td> <td>Less Active</td> <td>Average</td> <td>More Active</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Don't Know	Less Active	Average	More Active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, etc. <input type="checkbox"/> None	Compared to other children of the same age, how well does he/she carry them out?									
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V. 1. About how many close friends does your child have? None 1 2 or 3 4 or more

2. About how many times a week does your child do things with them? less than 1 1 or 2 3 or more

VI. Compared to other children of his/her age, how well does your child:

	Worse	About the same	Better
a. Get along with his/her brothers & sisters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Get along with other children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Behave with his/her parents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Play and work by himself/herself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VII. 1. Current school performance—for children aged 6 and older:

Does not go to school

	Failing	Below average	Average	Above average
a. Reading or English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Arithmetic or Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Spelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other academic subjects—for example: history, science, foreign language, geography.				
e. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Is your child in a special class?

No Yes—what kind?

3. Has your child ever repeated a grade?

No Yes—grade and reason

4. Has your child had any academic or other problems in school?

No Yes—please describe

When did these problems start?

Have these problems ended?

No Yes—when?

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VIII. Below is a list of items that describe children. For each item that describes your child **now or within the past 6 months**, please circle the **2** if the item is **very true** or **often true** of your child. Circle the **1** if the item is **somewhat** or **sometimes true** of your child. If the item is **not true** of your child, circle the **0**. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0	1	2	1. Acts too young for his/her age	16	0	1	2	31. Fears he/she might think or do something bad			
0	1	2	2. Ailergy (describe): _____		0	1	2	32. Feels he/she has to be perfect			
			_____		0	1	2	33. Feels or complains that no one loves him/her			
0	1	2	3. Argues a lot		0	1	2	34. Feels others are out to get him/her			
0	1	2	4. Asthma		0	1	2	35. Feels worthless or inferior	50		
0	1	2	5. Behaves like opposite sex	20	0	1	2	36. Gets hurt a lot, accident-prone			
0	1	2	6. Bowel movements outside toilet		0	1	2	37. Gets in many fights			
0	1	2	7. Bragging, boasting		0	1	2	38. Gets teased a lot			
0	1	2	8. Can't concentrate, can't pay attention for long		0	1	2	39. Hangs around with children who get in trouble			
0	1	2	9. Can't get his/her mind off certain thoughts; obsessions (describe): _____		0	1	2	40. Hears things that aren't there (describe): _____			
			_____					_____	55		
0	1	2	10. Can't sit still, restless, or hyperactive	25	0	1	2	41. Impulsive or acts without thinking			
0	1	2	11. Clings to adults or too dependent		0	1	2	42. Likes to be alone			
0	1	2	12. Complains of loneliness		0	1	2	43. Lying or cheating			
0	1	2	13. Confused or seems to be in a fog		0	1	2	44. Bites fingernails			
0	1	2	14. Cries a lot		0	1	2	45. Nervous, highstrung, or tense	60		
0	1	2	15. Cruel to animals	30	0	1	2	46. Nervous movements or twitching (describe): _____			
0	1	2	16. Cruelty, bullying, or meanness to others					_____			
0	1	2	17. Day-dreams or gets lost in his/her thoughts		0	1	2	47. Nightmares			
0	1	2	18. Deliberately harms self or attempts suicide		0	1	2	48. Not liked by other children			
0	1	2	19. Demands a lot of attention		0	1	2	49. Constipated, doesn't move bowels			
0	1	2	20. Destroys his/her own things	35	0	1	2	50. Too fearful or anxious	65		
0	1	2	21. Destroys things belonging to his/her family or other children		0	1	2	51. Feels dizzy			
0	1	2	22. Disobedient at home		0	1	2	52. Feels too guilty			
0	1	2	23. Disobedient at school		0	1	2	53. Overeating			
0	1	2	24. Doesn't eat well		0	1	2	54. Overtired			
0	1	2	25. Doesn't get along with other children	40	0	1	2	55. Overweight	70		
0	1	2	26. Doesn't seem to feel guilty after misbehaving					56. Physical problems without known medical cause:			
0	1	2	27. Easily jealous		0	1	2	a. Aches or pains			
0	1	2	28. Eats or drinks things that are not food (describe): _____		0	1	2	b. Headaches			
			_____		0	1	2	c. Nausea, feels sick			
			_____		0	1	2	d. Problems with eyes (describe): _____			
0	1	2	29. Fears certain animals, situations, or places, other than school (describe): _____		0	1	2	e. Rashes or other skin problems	75		
			_____		0	1	2	f. Stomachaches or cramps			
0	1	2	30. Fears going to school	45	0	1	2	g. Vomiting, throwing up			
					0	1	2	h. Other (describe): _____			

Please see other side

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0 = Not True (as far as you know)			1 = Somewhat or Sometimes True			2 = Very True or Often True			
0	1	2	57.	Physically attacks people	0	1	2	84.	Strange behavior (describe): _____
0	1	2	58.	Picks nose, skin, or other parts of body (describe): _____					_____
				80	0	1	2	85.	Strange ideas (describe): _____
0	1	2	59.	Plays with own sex parts in public	0	1	2	86.	Stubborn, sullen, or irritable
0	1	2	60.	Plays with own sex parts too much	0	1	2	87.	Sudden changes in mood or feelings
0	1	2	61.	Poor school work	0	1	2	88.	Sulks a lot
0	1	2	62.	Poorly coordinated or clumsy					45
0	1	2	63.	Prefers playing with older children	0	1	2	89.	Suspicious
0	1	2	64.	Prefers playing with younger children	0	1	2	90.	Swearing or obscene language
0	1	2	65.	Refuses to talk	0	1	2	91.	Talks about killing self
0	1	2	66.	Repeats certain acts over and over; compulsions (describe): _____	0	1	2	92.	Talks or walks in sleep (describe): _____
					0	1	2	93.	Talks too much
0	1	2	67.	Runs away from home	0	1	2	94.	Teases a lot
0	1	2	68.	Screams a lot					50
0	1	2	69.	Secretive, keeps things to self	0	1	2	95.	Temper tantrums or hot temper
0	1	2	70.	Sees things that aren't there (describe): _____	0	1	2	96.	Thinks about sex too much
					0	1	2	97.	Threatens people
					0	1	2	98.	Thumb-sucking
									55
					0	1	2	99.	Too concerned with neatness or cleanliness
					0	1	2	100.	Trouble sleeping (describe): _____
0	1	2	71.	Self-conscious or easily embarrassed	0	1	2	101.	Truancy, skips school
0	1	2	72.	Sets fires	0	1	2	102.	Underactive, slow moving, or lacks energy
0	1	2	73.	Sexual problems (describe): _____	0	1	2	103.	Unhappy, sad, or depressed
				30	0	1	2	104.	Unusually loud
0	1	2	74.	Showing off or clowning	0	1	2	105.	Uses alcohol or drugs (describe): _____
0	1	2	75.	Shy or timid	0	1	2	106.	Vandalism
0	1	2	76.	Sleeps less than most children	0	1	2	107.	Wets self during the day
0	1	2	77.	Sleeps more than most children during day and/or night (describe): _____	0	1	2	108.	Wets the bed
									65
0	1	2	78.	Smears or plays with bowel movements	0	1	2	109.	Whining
0	1	2	79.	Speech problem (describe): _____	0	1	2	110.	Wishes to be of opposite sex
				35	0	1	2	111.	Withdrawn, doesn't get involved with others
0	1	2	80.	Stares blankly	0	1	2	112.	Worrying
0	1	2	81.	Steals at home				113.	Please write in any problems your child has that were not listed above:
0	1	2	82.	Steals outside the home	0	1	2		70
0	1	2	83.	Stores up things he/she doesn't need (describe): _____	0	1	2		_____
				40	0	1	2		_____

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS.

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UNDERLINE ANY YOU ARE CONCERNED ABOUT.