Patient Information: Minor ***(Please fill in completely. If there is no information for a question, please put NA)***

NAME _____ AGE _____ SEX _____

BIRTHDATE ____/____/____ SOCIAL SECURITY #_____ PHONE _____

PHYSICAL ADDRESS _____
(necessary in case of emergency)

MAILING ADDRESS _____
(if different than physical)

I prefer to be notified:

EMAIL: _____

MEDICAL/PSYCHOLOGICAL HISTORY

CALL TEXT EMAIL

KNOWN PROBLEMS (INCLUDING HOSPITALIZATIONS, SURGERIES, APPROXIMATE DATES) _____

_____

PREVIOUS MENTAL HEALTH TREATMENT (PLEASE LIST APPROXIMATE DATES) _____

_____

PREVIOUS AND CURRENT MEDICATIONS (PLEASE INDICATE CURRENT MEDS) _____

_____

ALLERGIES _____

DRUGSTORE NAME _____ PHONE _____

PRIMARY CARE DR. _____ PHONE _____

WHO REFERRED YOU? _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO. _____ PHONE _____

INSURED'S NAME _____

POLICY # _____ GROUP # _____

SECONDARY INS. CO. _____ PHONE _____

INSURED'S NAME _____

POLICY # _____ GROUP # _____

MOTHER'S INFORMATION

NAME _____ HOME PHONE _____

ADDRESS _____ CELL _____

EMPLOYER _____ WORK PHONE _____

FATHER'S INFORMATION

NAME _____ HOME PHONE _____

ADDRESS _____ CELL _____

EMPLOYER _____ WORK PHONE _____

STEP-PARENT OR ADDITIONAL EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____ HOME PHONE _____

ADDRESS _____ CELL _____

EMPLOYER _____ WORK PHONE _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.	I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MY TREATING PROVIDER OR SUPPLIER OF SERVICES.
SIGNATURE _____ DATE _____	SIGNATURE _____

I VERIFY THAT TO THE BEST OF MY KNOWLEDGE, THE ABOVE PATIENT INFORMATION IS ACCURATE

Signature Of Patient Or Responsible Adult _____ **Date** _____

Albemarle Psychological Services
Post Office Box 303
Elizabeth City, North Carolina 27907-0303
(252) 338-8821

Offices

301 East Church Street
Elizabeth City, NC

Martin's Point Professional Center
6365 Croatan Highway, Suite A
Kitty Hawk, NC

Roger D. Allen, Ph.D.
Catherine A. McGrogan, Ph.D.
Clinical and Consulting Psychologists

LIMITS TO CONFIDENTIALITY

The information you provide to us is considered confidential and will not be released without your permission, with a few exceptions.

If you reveal information that you are a danger to yourself or to others, we may be required to contact your family, intended victims, or the police.

North Carolina law requires that we must report child abuse and neglect to the proper authorities.

If you have been involved in serious criminal activity, we may be required to notify legal authorities.

If your attorney or an opposing attorney subpoenas us to court, we can be ordered by a judge to reveal confidential information.

If you have any questions regarding these limits of confidentiality, please talk with Dr. Allen or Dr. McGrogan before you reveal any information having to do with the above issues.

I understand the above limits to my confidentiality.

_____ _____

Signature Date

_____

Witness

Albemarle Psychological Services
Post Office Box 303
Elizabeth City, North Carolina 27907-0303
(252) 338-8821

Offices

301 East Church Street
Elizabeth City, NC

Martin's Point Professional Center
6365 Croatan Highway, Suite A
Kitty Hawk, NC

Roger D. Allen, Ph.D.
Catherine A. McGrogan, Ph.D.
Clinical and Consulting Psychologists

PERMISSION FOR TREATMENT OF A CHILD

I, _____, certify that I am the _____of
(your name) (relationship to the child)

_____.
(child's name)

I am requesting that this child receive diagnostic and/or treatment services from Albemarle Psychological Services. I further certify that:

____ (1) I am the legal parent of this child and I am currently married to, and not separated from, the other legal parent of this child.

____ (2) I am the legal parent of this child and the other legal parent is deceased.

____ (3) I am the legal parent of this child. I am divorced or separated from the other legal parent and a court has awarded me sole legal custody of this child.

____ (4) I have physical custody, but there are no signed custody papers and the court has not yet decided on the custody.

____ (5) I have physical and/or legal custody and am designated by _____ to authorize treatment of this child. (In this case, you must provide proof of this authorization).

____ (6) I am the legal parent of this child. I am divorced or separated from the other legal parent of this child and we have joint custody. (In this case both parents must sign this form.)

_____ _____
Signature Date

_____
Witness

Albemarle Psychological Services

Post Office Box 303
Elizabeth City, North Carolina 27907-0303
(252) 338-8821

Offices

301 East Church Street
Elizabeth City, NC

Martin's Point Professional Center
6365 Croatan Highway, Suite A
Kitty Hawk, NC

Roger D. Allen, Ph.D.
Catherine A. McGrogan, Ph.D.
Clinical and Consulting Psychologists

FORENSIC SERVICE POLICY

At times, clients find it necessary for a psychologist to act as an expert witness in either civil or criminal matters. The American Psychological Association and the North Carolina Psychology Licensing Board have determined that it is unethical for a psychologist to act as an expert witness for a client that they have also seen for psychotherapy. This means that if you are coming to see us for therapy you must arrange to see another psychologist for an evaluation so that they can act as an expert witness for you if you require this service. If you are coming to us for an evaluation so that we may act as an expert witness for you, then we cannot see you for therapy. If you are a therapy patient and your attorney subpoenas us as a fact witness, we may give no conclusions, opinions, or recommendations. We cannot bill healthcare insurance for forensic services. If you have questions about this policy or if you have any legal actions pending for which you might require the services of a psychologist, please discuss this with Dr. Allen or Dr. McGrogan at your first appointment so that our role can be clarified from the outset. WE CANNOT PROVIDE BOTH SERVICES FOR YOU.

This Forensic Policy applies most frequently to divorce/custody proceedings. For example, if we have seen a child for treatment, should the parents separate, we cannot give any legal opinions regarding custody or visitation. If a psychological opinion is needed for a situation like this, the parties involved need to obtain a separate forensic evaluation from another provider not in our practice.

FORENSIC SERVICE FEE POLICY

There will be a $3000.00 retainer due prior to any evaluation, testing, consultation with your attorney or court appearance. As the evaluation continues you will be required to add additional money to your retainer as the psychologist's time is billed against the retainer. Whether we are ***Expert*** or ***Fact*** Witnesses, time will be billed as follows:

$3000.00	For court time, billed only in units of whole days.
$300.00	Per hour for time used for evaluation, testing, report writing, obtaining information from sources, court preparation, attorney consultation, any other psychologist's time.

These fees are ***NOT*** billable to your health insurance. They will be deducted from the $3000.00 retainer. If any amount of the retainer remains after your forensic work is finished, we will issue you a refund with an itemized statement.

I understand the above Forensic Service Policy and agree to the above Forensic Service Fee Policy for services as both an expert and fact witness. I understand that this document is a binding contract and I have received a copy of this document.

HAVE YOU RECENTLY, ARE YOU CURRENTLY, OR ARE YOU IN A SITUATION THAT IS LIKELY TO RESULT IN ANY KIND OF LEGAL ACTION?
YES _____ (☐ CIVIL OR ☐ CRIMINAL ?) NO _____

IF YES, ATTORNEY'S NAME AND ADDRESS: _____

_____ _____
Signature Date

_____
Witness