Child
12/2025

Psychology Health Group

A Group of Independent Practitioners

Family Physician_______________________________ Referred by __________________________________

Legal Full Name____Age_____Birthdate___/___/______
Preferred Name_____________________Gender_________ School Attending ________________Grade______
Address___________________________________ City ________________ State _________ Zip _________
Home/Cell Phone __________________ Parent/Guardian Email _________________________________
Parent/Guardian Name _____________________________________ Home/Cell Phone___________________
Parent/Guardian Address ________________________ City _________________ State ______ Zip _______
Employer _______________ Work Phone ________________ Parent/Guardian SS# ______-______-________
Parent/Guardian Name _____________________________________Home/Cell Phone___________________
Parent/Guardian Address ________________________City ________________ State ______ Zip _________
Employer _______________ Work Phone ________________ Parent/Guardian SS# ______-______-________

Who may we contact in case of emergency or appointment change and cannot reach you?

Name___________________________ Relationship__________________ Phone_______________________

INSURANCE INFORMATION: Please complete in full. Insurance billing is a courtesy. It is important that we have all necessary insurance information in order to submit your claims correctly.

Primary Insurance or EAP_________________Policy Number________________ Group Number __________
Claims Address____ Authorization# ____________________
Policy Holder _____________________ Policy Holder's Birthdate___________ Employer ________________

Secondary Insurance____________________ Policy Number________________ Group Number___________
Claims Address____ Authorization#____________________
Policy Holder_____________________ Policy Holder's Birthday_____________ Employer ________________

PATIENT RIGHTS AND RESPONSIBILITIES

I have reviewed Psychology Health Group's brochure which outlines policies with regard to patient rights and responsibilities. I acknowledge that I have been provided an opportunity to ask questions regarding this policy. **I agree to contact my insurance company to determine if authorization is needed.** I also understand that the patient or other responsible party is responsible for payment of fees unless otherwise agreed upon. I direct the insurer to pay, without equivocation, directly to Psychology Health Group all benefits due as a result of visits at Psychology Health Group. I further understand that I may be charged for any missed appointments or for appointments that are cancelled without sufficient notice. I also understand that failure to meet the financial obligations related to coming to the office may result in disruption of services and/or being turned over to a collection agency.

I give my consent to be treated at Psychology Health Group.

RELEASE OF INFORMATION

I authorize Psychology Health Group to release information necessary for billing only to my insurance company and/or financially responsible party. I authorize Psychology Health Group to release treatment plans necessary for authorization to my insurance company. **I also authorize Psychology Health Group to release information to the referring individual or organization and to my family physician.** I further acknowledge and authorize that my records may be anonymously reviewed by other members of Psychology Health Group for the purpose of treatment review and crisis management.

Signature____ **Date** ________________________

Relationship to patient____

Signature____ **Date**________________________

Relationship to patient____