

Shelby Psychological Services Minor Patient Registration Form

PATIENT INFORMATION				
Name		Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
Street Address		City	State	Zip Code
School	Grade	Patient /Guardian Employer		Work Phone ()
Responsible Party's Email Address			Home Phone ()	
Primary Care Physician Name:			Cell Phone ()	
How Did you Hear About Us? <input type="checkbox"/> Physician <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Insurance Co. <input type="checkbox"/> Other _____				

INSURANCE INFORMATION			
Primary Insurance			(Please provide your insurance card for office to copy)
Policy Holder's Social Security #		Birth Date	Policy Holder's Name
Policy Number		Employer	Group number
Patient's Relationship to Policy Holder		Secondary Insurance	
Policy Holder's Name		Birth Date	Policy Holder's Name
Policy Number		Employer	Group number
Patient's Relationship to Policy Holder		Person Responsible for Bill and address if different	

Your Signature

- Acknowledges:
- ⤴ Accuracy of above information and financial responsibility to pay any balance and attorney if required for account collection
 - ⤴ Notice of HIPPA and State of Alabama policy and practices to protect your health information
 - ⤴ Consent for me or my minor child to be evaluated and/or treated by Shelby Psychological Services (SPS)
 - ⤴ Dr. Vance has a small therapy-dog-in-training at SPS – we understand it is our responsibility to inform SPS staff if we do not want to interact with the dog

- Authorizes:
- ⤴ SPS to release information required to process my insurance claim and for insurance benefits to be paid to SPS
 - ⤴ Consent to release treatment information to SPS providers only in the event of an interoffice referral
 - ⤴ Consent to release requested information to the referring physician/source
 - ⤴ Consent to release information for insurance purposes, when required, with supervising providers

I have read, understand and acknowledge/authorize the above.

Signature of Patient (if age 14 & older) Printed Name of Patient Date

Signature of Parent/Guardian Printed Name of Parent/Guardian Date

CHILD PATIENT INFORMATION

(To be completed if the patient is 18 years or younger)

Child's Full Name: _____
Child is called: _____
Present School: _____ Grade: _____
Does your child receive any special education services? _____
If yes, please describe: _____
Has your child repeated a grade? _____
If yes, please describe: _____
Has your child been involved the legal system? _____
If yes, please describe: _____

Primary Care Physician/Pediatrician Name: _____
Phone: _____ Address: _____

May I contact him/her regarding your child's care? Yes _____ No _____

Is your child adopted? _____ If yes, at what age: _____
Child's biological or adopted parents are:
__ living together __ separated __ divorced
__ father deceased __ mother deceased __ father remarried __ mother remarried

Biological/Adopted Father's Full Name: _____
Address: _____
Biological/Adopted Mother's Full Name: _____
Address: _____
Stepfather's Full Name: _____
Stepmother's Full Name: _____
The child lives with: _____ Relationship to child: _____
(If applicable) Child is in Legal Custody of: _____
_____ joint or _____ full
(please have the front desk staff make a copy of the custody papers)

Siblings:

Names	Age	Full/Half/Step	Grade

Brief statement of your concerns and goals for treatment:

**Shelby Psychological Services
FINANCIAL AGREEMENT**

Patient/Guardian/Responsible Party Name:

Please remember that insurance is considered a method of reimbursing the patient for the fee paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Testing services are not always reimbursed. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL THE COST OF BILLINGS, IT IS REQUESTED THAT THE CHARGES FOR OFFICE VISITS BE PAID AT THE TIME OF THE VISIT. APPOINTMENTS NOT CANCELED 24 HOURS PRIOR TO THE SCHEDULED TIME WILL BE CHARGED AT THE REGULAR RATE. Automated reminder calls are sent out as a courtesy. However, computers do sometimes malfunction and phone numbers change etc. **YOU ARE STILL RESPONSIBLE TO KEEP YOUR APPOINTMENTS OR CANCEL ON A TIMELY BASIS** even if the reminder system does not work.

_____ Please initial

If a provider receives a subpoena with an order to appear for court proceedings regarding this case, it is the client/guardian's responsibility to reimburse the provider for their time. This includes preparation time, travel time and actual time at court at the cost of \$200/hour. A retainer fee of \$1000 is required at the time of the request. _____ Please initial

If this account is assigned to an attorney for collection and/or suit, I agree to pay a reasonable attorney's fee and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical benefits, to include any major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and/or other health plans to Shelby Psychological Services.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Responsible Party Signature _____ Date _____