Shelby Psychological Services

Minor Patient Registration Form

PATIENT INFORMATION

Name	Birth Date	❒ Male ❒ 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?

❒ Physician ❒ Internet ❒ Yellow Pages ❒ Insurance Co. ❒ Other _____

INSURANCE INFORMATION (Please provide your insurance card for office to copy)

Primary Insurance	Policy Holder's Name

Policy Holder's Social Security #	Birth Date	Employer	Group number

Policy Number	Patient's Relationship to Policy Holder

Secondary Insurance

Policy Holder's Name	Birth Date	Employer	Group number

Policy 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 _____