PSYCHOTHERAPEUTIC RESOURCES
CHILD ADMINISTRATIVE INTAKE

____ _____ __________ __________ _________________
Last Name First Name MI Age DOB Male/Female Social Security #

Name of parent(s)/guardian who lives with minor:____

Street Address:____ Phone #: Home:_____________________
____ Work:_______________________
City State Zip Code Cell #:__________________
Legal custodian authorizing therapy of child:____
Relationship:__________________________Home Phone #:_______________ Work Phone #:________________
Address:____
(If not the same as above)
Other parent/guardian who has legal/physical custody of child:____
Address:____
Home Phone #:____________________ Cell Phone #:_____________________ Work Phone #:_______________
Is this person in agreement with decision for child to be seen? Yes/No

In case of emergency contact: Name:____ Phone #:_____________

Primary Insurance:____ Effective Date:_____________
(If policyholder is different than client information above):
____ ___________ ___________________
First Name MI Last Name DOB: Social Security #
Address: ____
Relationship to Client:______________________ Employer:__________________________________

Secondary Insurance:____
(If policy holder is different than the information above): Name:_____________________________
Address:__________________________________ Relationship to Client:___________________
Employer:____
***It is your responsibility to inform PR of changes in address, phone #, insurance coverage.**

Do you have a specific request for how you would like us to communicate with you?
(eg. mailings/telephone calls)? **Yes**________ **No**_______

(If yes, please complete a **<u>Request for Confidential Handling of Health Information</u>**.)
(Note: Our clinic name and phone number will show up on caller I.D. if we call you.)

_____ **Please initial** to acknowledge that you have read and consented to the billing terms and conditions which include:

1. Terms of Billing
2. Release of health information as needed for collection purposes
3. Medical benefit assignment

If you have any questions, your therapist would be happy to discuss them.

- -

Important policies are viewable on our website. (www.yourcaringresource.com) by clicking Policies. Please read our Notice of Privacy Practices, and Bill of Rights of Clients. Would you like a hard copy? YES____ NO_____
I have received "Welcome to Psychotherapeutic Resources." YES_____

_____________________________________ _____________
Signature (PARENT OR GUARDIAN) Date