

NEW CLIENT INFORMATION - CHILD/DEPENDANT

Patient Name _____	Birth Date ____ / ____ / ____
Address _____	Patient Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
City, State, Zip _____	Phone Number _____ <input type="checkbox"/> Okay to Leave Message

GUARDIAN CONTACT INFORMATION

Mother's Name _____	marital status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced
Address _____	
City, State, Zip _____	
Home Phone ____ - ____ - ____	<input type="checkbox"/> Okay to Leave Message
Mobile Phone ____ - ____ - ____	<input type="checkbox"/> Okay to Leave Message
Email Address _____	<input type="checkbox"/> Okay to Send Messages
Father's Name _____	marital status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced
Address _____	
City, State, Zip _____	
Home Phone ____ - ____ - ____	<input type="checkbox"/> Okay to Leave Message
Mobile Phone ____ - ____ - ____	<input type="checkbox"/> Okay to Leave Message
Email Address _____	<input type="checkbox"/> Okay to Send Messages

PRIMARY INSURANCE INFORMATION

Responsible Guardian/Insured _____	Relationship to Child _____
Insurance Carrier _____	ID Number _____
Phone Number _____	Group # _____
Insured's Name _____	Insured's DOB ____ / ____ / ____
Insured's Employer _____	Insured's SSN ____ - ____ - ____

EMPLOYEE ASSISTANCE PROGRAM (EAP) INFORMATION

EAP COMPANY _____	Auth Number _____
Phone Number ____ - ____ - ____	Do you plan to use your EAP Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No

I attest to that I, and/or my dependents, have insurance coverage with the abovementioned carrier(s) and I authorize Naperville Clinical Services to submit claims to my insurance and obtain any information applicable or required for treatment. I understand that I am financially responsible for payment of services not covered and/or co-payments and missed appointments. This shall serve as my signature for all documentation related to my treatment at Naperville Clinical Services and shall be valid throughout the duration of treatment.

Signature of Responsible Guardian _____ Date _____

CANCELLATION NOTICE AND MISSED APPOINTMENTS

We will call and/or email with an appointment reminder 24 hours prior to your visit. All cancellations or rescheduling requests must be received by our office 24 hours prior to your scheduled appointment. Payment will be required for all missed appointments and cancellations received less than 24 hours from your scheduled appointment date and time. Please note that charges for missed appointments cannot be billed to your insurance company, and will be your financial responsibility.

I Accept and Understand the Missed and Cancellation Policy above

Parent or Guardian Signature

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided information on the standards for privacy of individually identifiable health information. I recognize I may request a copy of these Privacy Practices in their entirety at any time.

Parent of Guardian Signature

Date

Printed Name

If you are signing as the client's representative, print your name: _____

Describe your relationship to the client: _____

AUTHORIZATION TO DISCLOSE INFORMATION TO PRIMARY CARE PHYSICIAN

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire 12 months from the date signed.

(Please print patient's name)

(Please print treating clinician's name)

- Release any applicable information to my Primary Care Physician
- Do not release information to my Primary Care Physician
- Do not currently have a Primary Care Physician

PRIMARY CARE PHYSICIAN INFORMATION

Physician Name _____	Phone _____
Address _____	
Suite / Unit _____	
City, State, Zip _____	