

Patient Name \_\_\_\_\_

Mailing Address:

Street \_\_\_\_\_

Home Telephone: \_\_\_\_\_

P O Box \_\_\_\_\_

Cell Telephone: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Work Telephone: \_\_\_\_\_

\_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender (circle) F M School \_\_\_\_\_ Grade \_\_\_\_\_

Mother's Name \_\_\_\_\_ Employer/Occupation \_\_\_\_\_

Father's Name \_\_\_\_\_ Employer/Occupation \_\_\_\_\_

Referred By \_\_\_\_\_ Primary Care Physician (PCP) \_\_\_\_\_

**I am responsible for all financial aspects of this account.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

As the legal guardian, I hereby give Clinical Psychology of Fort Smith permission to provide services (testing and/or treatment) to the above-named child. My signature below attests to my guardianship and gives permission for these services. I also agree that I will notify Clinical Psychology of Fort Smith immediately should guardianship of this child change.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance:**

Insured Name \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Secondary Insurance:**

Insured Name \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

I hereby authorize the release of psychological information necessary to process this and future claims and request payment on assigned claims be made directly to Clinical Psychology of Fort Smith.

Signature \_\_\_\_\_ Date \_\_\_\_\_