CLINICAL PSYCHOLOGY OF FORT SMITH

Child - Patient Information

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 ______________