Child/Adolescent Registration Form

(Please Print)

Today's Date	Appt. With	Whom may we thank for referring you?

CLIENT INFORMATION

Last Name, First Name, Middle Initial	Age	Birth Date	☐ Male ☐ Female ☐ Non-binary

Street Address	City	State	Zip Code

Client Lives with

Primary Care Physician	Phone:	Notify of your visit? ☐ Yes ☐ No
Psychiatrist Name	Phone:	Notify of your visit? ☐ Yes ☐ No

PARENT/GUARDIAN RESPONSIBLE FOR ACCOUNT

Last Name, First Name, Middle Initial	Birth Date

Billing Address if different than client's	City	State	Zip Code

Preferred Phone #	☐ Cell ☐ Landline	Confidential Msg/Txt ☐ Yes ☐ No	Alternate Phone #	☐ Cell ☐ Landline	Confidential Msg/Txt ☐ Yes ☐ No

Email Address

Please sign me up for the CORE CC email list ☐ Yes ☐ No

Please send me Appointment Reminders by: Email ☐ Yes ☐ No
Text Message ☐ Yes ☐ No
I prefer not to receive appointment reminders ☐

Employer's Name, Address, and Work Phone (Confidential VM ☐ Yes ☐ No)

Anything else you'd like us to know about communicating with you or your family

PARENT/GUARDIAN # 2

Last Name, First Name, Middle Initial	Birth Date

Address if different than client's	City	State	Zip Code

Preferred Phone #	☐ Cell ☐ Landline	Confidential Msg/Txt ☐ Yes ☐ No	Alternate Phone #	☐ Cell ☐ Landline	Confidential Msg/Txt ☐ Yes ☐ No

Email Address

Please sign me up for the CORE CC email list ☐ **Yes** ☐ **No**

Please send me Appointment Reminders by: Email ☐ Yes ☐ No
Text Message ☐ Yes ☐ No
I prefer not to receive appointment reminders ☐

Employer's Name, Address, and Work Phone (Confidential VM ☐ Yes ☐ No)

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PRIMARY INSURANCE INFORMATION		
Insured's Last Name, First Name, Middle Initial		Birth Date
Insurance Company		Phone Number
Insurance Billing Address		
Policy No.	Group No.	Client Relationship to Insured ☐ Self ☐ Dependent
SECONDARY INSURANCE INFORMATION (IF APPLICABLE)		
Insured's Last Name, First Name, Middle Initial		Birth Date
Insurance Company		Phone Number
Insurance Billing Address		
Policy No.	Group No.	Client Relationship to Insured ☐ Self ☐ Dependent

The above information is true to the best of my knowledge. I authorize CORE Connection Counseling to use and disclose my private health information for treatment, payment, and health care operations. I authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible for any balance. Furthermore, I have reviewed the Notice of Privacy Practices, Informed Consent and Office Policies. I fully understand and accept the terms of this practice. I have had the opportunity to ask questions which clarify the conditions under which I consent to treatment and give my permission to CORE Connection Counseling to provide evaluation, consultation, and/or psychotherapy for myself or my child/family.

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Parent/Guardian Signature Date

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12-17 Year Old Client Signature – I understand my privacy rights & terms of the practice and I consent to treatment. Date

Authorization to Secure Payment

I,_______________________________________authorize CORE Connection Counseling to process payment on my Visa, MasterCard, American Express or Discover for any **balance due for copays or self-pay accounts on the day of service,** and any balance that has not been paid **30 days after my bill is received. These charges will appear from** Colleen Hanson, LCSW, P.C. I understand that if my card is declined, CORE Connection may put my payment through on another day when funds become available. I further understand that if I miss a scheduled appointment and fail to provide 24 hours advance notice, I will be billed the l**ate cancellation/no show fee of $85 and my credit card will be charged on the day of the appointment**. I understand that I have given CORE Connection Counseling my Credit Card information. I have read and understand this authorization to secure payment. We also can scan your credit card and store securely if you would prefer this to entering below. Missed appointment fees will not be processed to a spending account card so if this is your primary card on file, we do require an additional debit or credit card for this purpose.

My credit card information is as follows:

____

Name on Credit Card

____

Signature of Card Holder Today's Date

____

Credit Card Account Number

______________ ______________ ____________________

Expiration Date 3-4 Dig. Sec. Code Zip Code of CC Billing Address

Is this a debit card? ☐ Yes ☐ No

Is this a spending account card? ☐ Yes ☐ No