Sibling(s) full Name(s): Full/half/step Age: Lives with?

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Has your child seen a psychologist before?_____

Problem which is of concern to you:_____

Who is your child's primary care physician?_____

May I contact him/her? Yes____ No_____ Telephone number?_____

How did you select our office?_____

May we let your referral source know you have contacted us?_____

Person responsible for account?_____

Billing Address?_____

CANCELLATION POLICY: If you need to reschedule or cancel an appointment, please call at least 24 hours in advance. If you are a "No Show" for an appointment, regular fees will be charged to you for that time. Sudden emergencies or illnesses can be discussed.

FINANCIAL RESPONSIBILITY STATEMENT: I understand that I am responsible for all of the charges incurred for services provided to me and/or my family. I agree to pay my account as services are provided unless other arrangements are made. If there is an outstanding balance on my account, I agree to pay it as soon as I receive notice that it is due.

_____ _____

Signature of person completing this form Date