



Responsive Centers for Psychology and Learning

7501 College Boulevard, Suite 250 ♦ Overland Park, Kansas 66210

Telephone: (913) 451-8550 ♦ Fax: (913) 469-5266

Patient Registration Form - Child

Today's date:		Therapist:			
PATIENT INFORMATION					
Patient's Last Name:		First Name:		Middle Initial:	Birth date: / /
Age:		Street Address:		City:	State: Zip:
Home Phone: ()		Cell Phone: ()		Sex:	Social Security #:
School:		Grade:	Teacher/Counselor:		School District:
Referred by: <input type="checkbox"/> Physician <input type="checkbox"/> Family member <input type="checkbox"/> School <input type="checkbox"/> Friend <input type="checkbox"/> Other					
Name:					
MOTHER'S INFORMATION					
Last Name:		First Name:		Middle Initial:	Birth Date: / /
Social Security #:		Home Phone: ()		Cell Phone: ()	
Work Phone: ()		Street Address:		City:	State: Zip:
Employer:		City:		State:	Zip:
FATHER'S INFORMATION					
Last Name:		First Name:		Middle Initial:	Birth Date: / /
Social Security #:		Home Phone: ()		Cell Phone: ()	
Work Phone: ()		Street Address:		City:	State: Zip:
Employer:		City:		State:	Zip:
DIVORCE POLICY					
<p>We recognize that many children live with two separate families. While you and your child's other parent may have an agreement about paying for health-related appointments, we are not able to be an intermediary in that process. The parent who signs the paperwork at the initial visit will be considered the responsible party for all patient balances.</p> <p>Unless you provide us with a court order indicating one parent has sole custody, any information in our possession concerning a minor child will be provided, upon request, to either or both parents.</p> <p>I have read and understand the above stated policies.</p>					
Signature _____			Date _____		

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Patient Registration Form – Child (cont'd)

EMERGENCY INFORMATION		
Last Name:	First Name:	Relationship to child:
Home Phone: ())	Work Phone: ())	Cell Phone: ())

FINANCIAL POLICY

All payments will be collected at *check-in* during regular business hours.

Co-pays for patients covered by insurance are due at the time services are rendered. Anytime our receptionist is unavailable, please place your payment in the lockbox to the left of the receiving window in the waiting area, or pay your therapist immediately following your appointment.

If your clinician does not participate with your insurance company, or if you choose not to use your insurance benefits, payment in full is due at the time of service. Upon request, we will provide you with a Visit Summary form to file with your insurance company for reimbursement.

It is your responsibility to obtain prior authorization through your insurance company, if required. Failure to do so may result in out-of-pocket expense.

Your therapist reserves the right to charge you if you fail to notify the office of a cancellation 24 hours prior to your scheduled appointment.

I have read and understand the above stated policies.

Signature

Date

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Child's Name:			Therapist:		
PRIMARY INSURANCE INFORMATION					
Primary Policy holder is: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Neither					
If NEITHER please provide the following information about the primary policy holder:					
Primary Policy Holder Last Name:		First Name:	Middle Initial:	Birth Date: / /	Social Security #:
Street Address:			City:		State: Zip:
Home Phone: ()	Work Phone: ()		Cell phone: ()	Relationship to patient:	
Please complete the following only if you are unable to supply a copy of your card:					
Primary Insurance Company Name:		ID #: Group #:		Phone #: ()	
Street Address:		City:		State: Zip:	
SECONDARY INSURANCE INFORMATION (if applicable)					
Secondary Policy holder is: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Neither					
If NEITHER please provide the following information about the secondary policy holder:					
Secondary Policy Holder Last Name:		First Name:	Middle Initial:	Birth Date: / /	Social Security #:
Street Address:			City:		State: Zip:
Home Phone: ()	Work Phone: ()		Cell phone: ()	Relationship to patient:	
Please complete the following only if you are unable to supply a copy of your card:					
Secondary Insurance Company Name:		ID #: Group #:		Phone #: ()	
Street Address:		City:		State: Zip:	
AUTHORIZATION OF PAYMENT					
Please Choose ONE of the following:					
<input type="checkbox"/> The above named child is a private payment patient. I will be responsible for payment in full at the time each service is rendered.					
Signature: _____			Date: _____		
<input type="checkbox"/> I authorize payment of insurance benefits to Responsive Centers for Psychology and Learning, 7501 College Boulevard, Suite 250, Overland Park, KS 66210 for services rendered. I further authorize the release to my insurance company of any medical or other information necessary to process my insurance claims. I understand that I am responsible for all balances unpaid by my insurance company including, but not limited to, deductibles and co-pays.					
Signature: _____			Date: _____		

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BIOGRAPHICAL INFORMATION

This information is to help your psychologist or therapist prepare for your visit and to facilitate treatment planning.

Name: _____ Nick Name: _____ DOB: _____ Age: _____

PRESENTING PROBLEMS

What concerns or problems, including symptoms, convinced you to seek help for your child now? _____

On the scale below please check the severity of the problem(s):

Mildly upsetting Moderately severe Very severe Extremely severe Incapacitating

How long has this been a problem? _____ Has your child been treated for this problem before? _____

If yes, who treated your child? _____

FAMILY INFORMATION

Mother's Name: _____ Phone: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

Father's Name: _____ Phone: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status of Parents: Married to each other Remarried Divorced Separated Significant Other

If parents are separated or divorced, which parent has legal authority to health care decisions: _____

Sibling names and ages: _____

Others living in the home: _____

If parents are divorced or separated please provide the current custody arrangements: _____

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EDUCATIONAL HISTORY

Special education or special needs: yes no If yes, please explain: _____

Has your child ever had psychological and/or educational testing? yes no If yes, please summarize the results: _____

Does your child have an Individual Education Plan or 504 Plan in place? yes no

Is your child frequently absent from school? yes no If yes, please explain: _____

How would you describe school behavior, grades, and progress? _____

MEDICAL HISTORY

Primary Care Physician: _____ Date of last physical exam: _____

Medical problems your child is being treated for currently: _____

Allergies: _____

Current medications: _____

PSYCHIATRIC HISTORY

Previous mental health treatment? yes no Level of care? Inpatient Partial hospital Outpatient

Reason for treatment : _____

Treating therapist(s)' name(s): _____

Has your child ever attempted suicide? yes no If yes, when: _____

Is your child currently having suicidal ideation? yes no don't know

Does your child have a plan? yes no don't know

Family history of psychiatric problems. Describe: _____

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ALCOHOL/DRUG USE/ABUSE

Family member(s) abuse? yes no If yes, who? _____

LEGAL HISTORY

Has your child ever been arrested? yes no If yes, for what reason and age: _____

SOCIAL HISTORY

Is your child able to make friends? yes no Is your child able to maintain friendships for over a year? yes no

Is your child frequently bullied or severely teased? yes no don't know

RELIGION

How strong are your family's religious beliefs or practices? Very Strong Moderate Not Strong NA

Patient's Rights and Responsibilities

Patients have the right to:

- Be treated with professionalism and respect
- Confidentiality (see Notice of Privacy Rights)
- Receive explanations about office procedures, or answers to any questions you may have
- Participate in decisions regarding treatment planning
- Consent to or refuse any treatment

Patients also have the responsibility to:

- Provide information needed by the professional staff to care for you
- Keep all scheduled appointments and be on time, and to cancel at least 24 hours in advance if you are unable to keep an appointment
- Pay your fees, deductibles, and co-payments
- Provide insurance information if you wish to use your insurance benefits

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Report to Primary Care Physician

I authorize **Responsive Centers** to release information to my primary care physician. _____
Patient Signature

Please provide the following information so that we are able to contact your physician.

Patient Name:	Patient DOB:
Patient Social Security Number:	Authorization # (if applicable)
Physician Name:	Physician Phone #:
Physician Address:	Physician Fax #:

I **DO NOT** authorize **Responsive Centers** to release information to my primary care physician. _____
Patient Signature

FOR OFFICE USE ONLY

This is a (n) Initial Summary Interim summary Termination Summary

Suggested Diagnoses

Axis I: _____

Axis II: _____

Psychotropic Medications

Current psychotropic medications: _____

Please evaluate this patient for the appropriateness of medication for the treatment of _____

Treatment Goals

Treatment Modalities: Individual therapy

Family therapy Group therapy Couples therapy

Psychotropic medication Referral to community resources _____

Psychologist/Therapist Signature

Date

Please complete and return if medication is prescribed or changed or if there are any medical conditions or medications that may be causing or contributing to the patient's symptoms of mental disorder.

Medication prescribed: _____ Dose: _____

Medication prescribed: _____ Dose: _____

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Physician Signature

Date

CONSENT TO TREAT - CHILD

Welcome to our practice. Please read this document carefully and note any questions you might have so you and your therapist can discuss them. *Once you sign this, it will constitute a binding agreement between us.*

NOTICE OF PRIVACY PRACTICES

By signing this agreement you consent to the use of your child's personal health information for purposes of treatment, payment, or healthcare planning according to the **Notice of Privacy Practices** posted on the Responsive Centers Website and provided at the Responsive Centers offices.

PSYCHOTHERAPY

Psychotherapy is a very individual matter. It varies depending on the personality of both the therapist and the child and the particular issues that are being addressed. There are a number of different approaches that can be used. Outpatient psychotherapy is voluntary and requires an active effort on the part of your child and cooperation of the parents. In order to be most successful, work will be required both during sessions and at home.

Psychotherapy has both benefits and risks. Psychotherapy often leads to a significant reduction of feelings of distress, better relationships, and resolutions to specific problems. Risks sometimes include experiencing uncomfortable levels of feelings such as sadness, guilt, anxiety, anger, frustration, loneliness, and/or helplessness. There are no guarantees about results.

By the end of the first few sessions, your therapist will be able to offer you an initial treatment plan for your child. You should evaluate this information along with your own assessment about whether you feel comfortable continuing. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. As the parent of the patient, you have the right to discontinue counseling at any time.

SESSIONS

If psychotherapy is initiated, 30-50 minute meetings will be scheduled at mutually agreed upon times, depending upon your child's ability to participate. *Once an appointment is scheduled, you will be expected to pay for it unless you provide 24-hours advance notice of cancellation (unless you and your therapist agree your child was unable to attend due to circumstances beyond your control).* Generally, missed appointments are not insurance reimbursable and must be paid for by the parent.

Your therapist will be happy to discuss session fees with you. You are expected to pay all co-pays at the time of each session. In addition to your appointments, we charge on a prorated basis for other professional services that are not insurance reimbursable such as report writing, telephone conversations that last longer than 10 minutes, attendance at meetings or consultations with other professionals that you have authorized or requested, preparation of records or treatment summaries, and/or the time required to perform any other services which you may request of your therapist.

CONFIDENTIALITY

Children represent a special circumstance with regard to confidentiality. Although parents have the right to full disclosure of the content of their child's therapy sessions, it is difficult to create and maintain a therapeutic relationship if the child believes what is said will be reported to the parents. For that reason, we ask that parents waive the right to parental disclosure. The specific information provided by the child will remain confidential but the therapist will share clinical information that (s)he deems appropriate at his/her discretion. As a mandated reporter, your child's therapist must report the following: 1.) a serious threat to do harm to self or other; 2.) the report of physical, sexual, or emotional abuse. In some circumstances, such as child custody proceedings and proceedings in which your child's emotional condition is an important element, a judge may require testimony.

INDEPENDENT PRACTICE

Responsive Centers for Psychology and Learning is an association of independently practicing professionals, which shares certain expenses and administrative functions. While members share a name and office space, they are completely independent in providing your child with clinical services and are fully responsible for those services. Any matters concerning your child's clinical care should be addressed with your child's therapist first. If the matter is not resolved to your satisfaction, you may contact our executive director.

Please note that your child's therapist is not authorized to practice medicine or prescribe medication, but will work closely with your physician to ascertain any medical or biological origins that may impact your child's symptoms.

I have read the above information and understand its contents. I give my full consent for treatment of my minor child and by signing this document I am also claiming I have the legal right to do so. I have had the opportunity to read and obtain a copy of the Notice of Privacy Practices either at the office or on the website.

Parent Signature

Witness

Parent Signature

Date

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