THE ALPHA CENTER
NOURISHING THE MIND, BODY & SPIRIT

NEW MINOR CLIENT REGISTRATION

If at any time questions or concerns regarding your therapy sessions arise, please let us know. Welcome. We want to make your appointments as pleasant and comfortable as possible.

Date:_____ Referred by: _____

Child's Name:_____ Preferred Name:_____

Date of Birth:_____ Age:_____ Sex:___ General Physician:_____

Address:_____ Specialist:_____

City/State/Zip:_____ Psychiatrist:_____

Phone:_____ School Counselor:_____

Mother's Information:

Name:_____ Place of Employment:_____

Address Same As Minor?: ☐ Yes ☐ No DOB:_____ Age:_____

Address:_____ Work Phone:_____

City/State/Zip:_____ Cell Phone:_____

Father's Information:

Name:_____ Place of Employment:_____

Address Same As Minor?: ☐ Yes ☐ No DOB:_____ Age:_____

Address:_____ Work Phone:_____

City/State/Zip:_____ Cell Phone:_____

Names of Siblings/Age/DOB

_____ ☐ M ☐ F

_____ ☐ M ☐ F

_____ ☐ M ☐ F

_____ ☐ M ☐ F

Person To Contact In Case of Emergency

Name:_____

Relationship:_____

Phone:_____

Signature of Parent or Guardian:_____ Date:_____

Please fill out all forms completely

855 Central Dr Suite 31B Odessa, Texas · 79761 · (432) 614-5720 · Fax (877) 729-4033

PERSONAL HISTORY INFORMATION

Please note: All information will be kept strictly confidential.

Briefly describe the problem(s) that brought the child into this office:_____

What have you done to try to resolve this problem?_____

Is the child currently receiving treatment or counseling? ☐ Yes ☐ No If so, when?_____

And whom did he/she see?_____

Describe the child's current physical health:_____

Describe the child's current mental state:_____

Has the child been under medical care (physical or psychological) during the past year? ☐ Yes ☐ No

If yes, please describe:_____

Serious or Prolonged Illnesses:_____

Medications the child is currently taking:_____

Has the child ever suffered a head or back injury? ☐ Yes ☐ No If yes, when?_____

Please describe:_____

Has the child ever had or do you think (or fear) the child may have a drug or alcohol abuse problem?

☐ Yes ☐ No If so, please describe:_____

Has either of the parents ever had or currently have a drug or alcohol abuse problem?

☐ Yes ☐ No If so, please describe:_____

Who currently lives in the home with the child?_____

Please list other information that we might find useful:_____

Signature of Parent or Guardian:_____ Date:_____

Please fill out all forms completely

PAYMENT AND INSURANCE INFORMATION

Please fill out all relevant information. Assignment cannot be accepted without your signature.

Method of Payment: ☐ Check/Cash ☐ Credit Card ☐ Insurance ☐ Other

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If you wish us to file on your insurance, please fill out all information completely.

Insurance provided by: ☐ Your Job ☐ Spouse's Job ☐ Other

Please provide your insurance card(s) if available.

1. Primary Coverage:_____
   Policy Holder Name:_____ Employee ID#:_____
   Social Security #:_____ Group #:_____
   Date of Birth:_____ Precertification Phone #:_____

2. Secondary Coverage:_____
   Policy Holder Name:_____ Employee ID#:_____
   Social Security #:_____ Group #:_____
   Date of Birth:_____ Precertification Phone #:_____

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY

In order for my insurance company to pay for my services, the counseling center will have to contact them for authorization. I understand this cannot be done without my written permission. I also understand this is a signed release for the express purpose of insurance payment and will be used for no other purpose.

Signature of Client:_____ Date:_____

AUTHORIZATION OF ASSIGNMENT OF BENEFITS AND PAYMENT OF SERVICES

I understand that my insurance policy is an agreement between the insurance carrier and myself and as such I have a personal responsibility to deal directly with my insurance company if difficulties arise. I, also, understand that this office will prepare necessary reports and forms to assist me in collecting payment from my insurance company and that any amount paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued payments in order to credit my account.

However, I understand that this agreement does not insure payment, nor does it relieve me of the obligation of payment of the services I have received and that all services rendered to me WILL BE charged directly to me. Therefore, I am personally responsible for full or partial payment.

Signature of Parent or Guardian:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act. Of 1996 ("HIPPA"). Under HIPPA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgement that this notice was received.

Therefore, I, *[please print name]*_____acknowledge that the counseling center has provided a written copy of its Notice of Privacy Practices for Protected Health Information for my review, on behalf of either myself or a client *[please specify]*_____ for whom I am acting as personal representative.

I further acknowledge that I have been provided with a copy of the counseling center's Notice of Privacy Practices for my records if I have made such a request.

_____ _____

Signature of Parent or Guardian Date

_____

Relationship to Client

_____ _____

Signature of Witness Date

PERSONAL HISTORY INFORMATION

TO BE FILLED OUT BY THE MINOR CHILD

Please note: All information will be kept strictly confidential.

What school do you go to?_____

What grade are you in?_____ How are your grades? A's B's C's F's

Who are you closest friends and how old are they?_____

_____

Do you have a boyfriend or girlfriend?_____ How old is he/she?_____

Who do you live with?_____

Do you like them?_____

How do you feel about being here?_____

_____

_____

Why are you here? What happened?_____

_____

_____

What do you think about yourself?_____

_____

_____

Do you use drugs or alcohol?_____ If so, how much and how often?_____

_____

Signature of Minor Child:_____ Date:_____

Please fill out all forms completely