**CHILD REGISTRATION FORM**

**Embracing Change Counseling Services, LLC**

1500 S Sycamore Ave, Suite 102

Sioux Falls, SD 57110

(605) 306-6383

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name Gender Date of Birth School & Grade

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Address: Street City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone(s): *for mobile phones, please indicate name AND number*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Name(s) Father Mother Custody held by

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Parent’s Marriage(s), Separation(s), Divorce(s)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent address & Phone *(if different than child’s)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of Education Father Mother

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer / Occupation Father Mother

**Insurance Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY: Policy Holder Name & Date of Birth Company ID # Group #

Does it cover Mental Health services? Yes□ No□ Not sure□

Is preauthorization required? Yes□ No□ Not sure□

Do you have a copay? Yes□ No□ Not sure□ If yes, what amount? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your deductible? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not sure□

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SECONDARY: Policy Holder Name & Date of Birth Company ID # Group #

Does it cover Mental Health services? Yes□ No□ Not sure□

Is preauthorization required? Yes□ No□ Not sure□

Do you have a copay? Yes□ No□ Not sure□ If yes, what amount? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your deductible? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not sure□

*(please complete other side)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others Living at Home: Name Gender Date of Birth School & Grade

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others Living at Home: Name Gender Date of Birth School & Grade

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Others Living at Home: Name Gender Date of Birth School & Grade

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Others Living at Home: Name Gender Date of Birth School & Grade

**Health Information**

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Referred by Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Concern or Complaint

Has child had any previous mental health treatment? Yes□ No□

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If yes, where and with whom?

Is child currently under the care of a physician? Yes□ No□

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Physician Phone

Please list medications child is currently taking:

Drug \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Schedule \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Schedule \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Schedule \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Authorization & Release**

If child was referred by a physician, it is often useful for your child’s therapist to confer with him/her regarding your child’s diagnosis and treatment.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(parent/guardian), give permission for my child’s therapist, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(therapist), to release records and/or information about my child’s treatment to my child’s physician for the purpose of treatment, planning and coordinating psychotherapy with my child’s health care needs. I may withdraw this consent at any time in writing or verbally, by advising the therapist named above.

I hereby authorize my child’s therapist to release necessary information to insurance carriers concerning my child’s diagnosis and treatment in order to process claims. In addition, I hereby authorize direct payment of medical payments to my child’s therapist for services rendered.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_