

COMMUNITY PSYCHOLOGICAL CONSULTANTS
11350 North Meridian Street, Suite 300
Carmel, Indiana 46032
An Association of Independent Health Practitioners
Phone: (317) 574-1785
Fax: (317) 574-1786

CHILD REGISTRATION FORM

Provider (check one): Mary L. Sanders, Ph.D., HSPP ___ Daniel H. Stauber, M.A., LCSW ___

Child's Full Name _____

Child's Preferred Name _____

Age _____ **Birth Date** _____ **Gender Preference** _____

Grade _____ **School** _____

Presenting Concerns _____

Parent Name _____ **Relationship** _____

Address _____

Preferred Phone Number (cell phone?) _____

Preferred Email Address _____

Marital Status _____ **Partner** (if appropriate) _____

Parent Name _____ **Relationship** _____

Address (if different from above) _____

Preferred Phone Number (cell phone?) _____

Preferred Email Address _____

Marital Status _____ **Partner** (if appropriate) _____

Parent Name _____ **Relationship** _____

Address (if different from above) _____

Preferred Phone Number (cell phone?) _____

Preferred Email Address _____

Marital Status _____ **Partner** (if appropriate) _____

Parent Name _____ **Relationship** _____

Address (if different from above) _____

Preferred Phone Number (cell phone?) _____

Preferred Email Address _____

Marital Status _____ **Partner** (if appropriate) _____

Legal and Physical Custody/Parenting Time Arrangements _____

Siblings (name, date of birth, relationship, primary residence) _____

Physician Name, Address, Phone Number _____

General Health History _____

Current Daily Medications (including dosage/administration) _____

Request for Confidential Handling of Health Information for:

____ Mary L. Sanders, Ph.D., HSPP

____ Daniel H. Stauber, M.A., LCSW

I, _____,

Parent, Guardian, or Responsible Party Name

give permission to the above provider to contact me or to otherwise transmit

confidential health information regarding services for _____.

Child's Name

Please check all that apply and provide the relevant information:

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____ U.S. Mail

____ Email

____ Home Telephone

____ Business Telephone

____ Cellular Phone

____ Fax

____ Other _____

Please complete the following section only if you want communication regarding your health care information sent to an alternate address (other than your residence).

Street Address, City, State, Zip Code

Referring physician/other professional: _____

Phone: _____ Fax: _____

Address: _____

Do I have permission to contact your physician or referring professional to coordinate care? Yes _____ No _____

Please note: Dr. Sanders does not directly bill insurance for her services. She will, at your request, provide you with a superbill that you can submit to your insurance company for possible out-of-network insurance reimbursement.

Mr. Stauber is an in-network provider for some insurance companies. If you are hoping to use insurance, please complete the following:

Client Name/Birthdate: _____

Insured's Name/Birthdate: _____

Primary Insurance: _____ Insured's Employer: _____

Member ID: _____ Group ID: _____

Provider Services Phone Number: _____ Effective Date: _____

ASSIGNMENT OF BENEFITS AND INDIANA MENTAL HEALTH PROFESSIONAL-PATIENT AGREEMENT

I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered. _____ (please initial)

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that if collection proceedings are necessary, I will pay all fees with collecting reimbursement for this bill. _____ (please initial)

I have received/read the mental health profession-patient services agreement and agree to its terms and also I have received the HIPAA information contained therein. _____ (please initial)

Payment is due at the time of service unless other arrangements are made. No-shows or cancellations made within twenty-four hours of a scheduled appointment may result in an out-of-pocket charge.

I have read and understand all of the above:

Client Name (please print full name) _____

Authorized Person's Signature _____ **Date** _____

Authorized Person's Name and Relationship to Client (please print)
