Mary L. Sanders, Ph.D.
COMMUNITY PSYCHOLOGICAL CONSULTANTS
190 Central Park Square, Suite 307
Los Alamos, New Mexico 87544
Phone: (317) 574-1785
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CHILD REGISTRATION FORM

Child's Full Name _____
Child's Preferred Name _____
Age_____ **Birth Date** _____ **Gender Preference** _____
Grade_____**School**_____
Presenting Concerns _____
_____
_____
Parent Name _____ R**elationship** _____
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 _____
_____
Physician Name, Address, Phone Number _____
_____
General Health History _____
_____
_____

Current Daily Medications (including dosage/administration) _____
_____
_____

Request for Confidential Handling of Health Information for:

I, _____,
Parent, Guardian, or Responsible Party Name
give permission to Mary L. Sanders, Ph.D. to contact me or to otherwise transmit confidential health information regarding services for _____
Child's Name
using (please check all that apply and provide the relevant information:
____ 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 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. If you are hoping to request out-of-network reimbursement from your insurance after full payment to Dr. Sanders, please indicate the name of the primary insured and the relationship of the primary insured to the client.
Client Name/Birthdate: _____
Insured's Name/Birthdate: _____

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)
_____