SCRIPPS RANCH CENTER FOR BEHAVIORAL HEALTH

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CLIENT REGISTRATION: CHILD FORM

1. Personal Information **Today's Date:**____________________

Child's Full
Name:____

Date of Birth:____________ Age:_____ Family's Religious Affiliation:______________________

Grade:________ School:___________________________ Teacher:__________________________

Address:____

City:________________________________ State__________________ Zip___________________

Home Phone: (____)____________________ Parent Cell Phone: (____)______________________

2. Responsible Party Information

Name of Responsible
Party:____

Address (if different than client's)____

Relationship:________________________ Birth Date:______________ SS#__________________

Place of Employment:______________________________ Length of Employment:____________

Home Phone: (____)__________Work Phone: (____)__________ Cell Phone: (____)__________

Name of Primary Health Insurance:_________________________ Authorization #___________

Group Number:_____________________ Policy/Subscriber Number:______________________

Address of Primary Insurance:_____________________________ Phone Number:____________

PAYMENT AUTHORIZATION

I understand that it is my responsibility to pay the fee established for professional services rendered to the above client. I hereby authorize insurance payment directly to Dr. Kenneth Heying or Dr. Brad Miller. Please note that 24 hours advance notice is required to cancel an appointment in order to avoid charges.

TREATMENT AUTHORIZATION

As parent/guardian of the above minor, I hereby authorize Kenneth R. Heying, Ph.D. or Brad Miller, Psy.D. (circle one) to provide psychological services, which may include counseling, testing or consultation.

Signature of Responsible Party:_________________________________Date:____________________