Integrative Psychological Services, LLC

501 N Frederick Ave Suite 310 Gaithersburg, MD 20877

---------- **Child/Adolescent Background Information**----------

Patient Name: _____ Date: _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: ___Male ___Female

Social Security Number: _____

Ethnicity: ___Asian ___Hispanic ___African-American ___Caucasian ___Other: _____

Name of Parent/Legal Guardian (s): _____

Complete Address: _____

_____

Contact Preferences:

Home Phone: _____ May I leave a message? Y/N

Cell Phone: _____ May I leave a message? Y/N

Email*: _____

May I email you? Y/N *Please be aware that email might not be confidential.

Name of Contact Person in Case of Emergency: _____

Telephone #: _____ Relationship: _____

Reason for seeking services: _____

Referred by: _____

PRIMARY INSURANCE: _____

CLAIMS ADDRESS: _____

_____

CUSTOMER SERVICE NUMBER: _____

ID#_____

GROUP ID: _____

NAME, BIRTH DATE, AND PHONE NUMBER OF THE SUBSCRIBER:

_____

_____

ADDRESS (if different) OF THE SUBSCRIBER AND RELATIONSHIP TO CLIENT

_____

_____

Please Note: insurance policies do not cover any services that are related to paperwork, legal, or learning and educational challenges. You are responsible for these charges.

Self-Pay Clients

Insurance Disclaimer for Direct Pay Clients

Some clients make a choice to not utilize the mental health benefits associated with their insurance because they prefer to maintain their privacy and/or control the direction of their care. When you utilize your health insurance benefits your insurance company will require that we provide them with a mental health diagnosis. Additionally, the insurance company may require access to your record to verify an accurate diagnosis and need for care. The insurance company may also dictate your treatment plan, type of therapy provided, and session limits. You may choose not to use your health insurance benefits whether they are in-network or out-of-network benefits.

Please sign below if you are choosing not to use your health care benefits (in-network or out-of-network) and are making the choice to pay directly for the services you receive at Integrative Psychological Services, LLC.

_____ _____

Parent/Guardian Signature Date

In-Network Clients (Blue Cross Blue Shield)

All Parents/Guardians Sign Here:

I certify that all the information I have provided above is accurate to the best of my knowledge.

_____ _____

Parent/Guardian Signature Date

Clients Using Insurance Benefits Please Sign Below:

I understand that certain information may be required by third party sources for the purpose of treatment, payment (including collections of past due accounts) and health care operations. I hereby consent to Integrative Psychological Services, LLC, releasing my health information for the purposes of treatment, payment, and healthcare operations. I hereby assign to the practice all benefits/payments from my insurance carrier for services rendered to my dependents and/or myself. I understand that I am responsible for all amounts not covered by my insurance.

_____ _____

Parent/Guardian Signature Date