COLUMBUS PSYCHOLOGICAL ASSOCIATES

CHILD PATIENT UPDATE FORM

CHILD'S NAME: ______________________ DATE OF BIRTH: ____________ SEX: M / F

HOME ADDRESS: ______________________ CITY: ____________

STATE: ____________ ZIP: ____________ SSN: ____________

HOME PHONE: ____________ WORK PHONE: ____________ CELL PHONE: ____________

HOW WOULD YOU LIKE YOUR APPT. REMINDER? TEXT / VOICE SPECIFY TELEPHONE #: ____________

PERSON WE SHOULD CONTACT IN CASE OF EMERGENCY: ______________________

EMERGENCY CONTACT PHONE #: ____________ RELATIONSHIP TO PATIENT: ____________

RESPONSIBLE PARTY: ____________ RELATIONSHIP TO PATIENT: ____________

HAVE THERE BEEN ANY CHANGES TO YOUR INSURANCE? YES / NO

PRIMARY INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE: ______________________

POLICYHOLDER'S FULL NAME: ______________________ DATE OF BIRTH: ____________

SSN: ____________ POLICY/ID NUMBER: ____________

GROUP NUMBER: ____________ INSURANCE PHONE #: ____________

SECONDARY INSURANCE INFORMATION

NAME OF SECONDARY INSURANCE: ______________________

POLICYHOLDER'S FULL NAME: ______________________ DATE OF BIRTH: ____________

SSN: ____________ POLICY/ID NUMBER: ____________

GROUP NUMBER: ____________ INSURANCE PHONE #: ____________

I CONSENT TO TREATMENT, I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO COLUMBUS PSYCHOLOGICAL ASSOCIATES.

I ACKNOWLEDGE I HAVE RECEIVED NOTICE OF COLUMBUS PSYCHOLOGICAL ASSOCIATES POLICIES AND PROCEDURES AND HIPAA NOTICE FORM.

PARENT SIGNATURE: ______________________ DATE: ____________