

**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: _____