Christopher & Associates
Evaluation and Counseling Center, Inc.

322 Dupont Drive, Suite A
Seymour, IN 47274
812-523-0386 Phone
812-523-8416 Fax

SCREENING INFORMATION (CHILD)

Please Print Clearly

THIS SHEET MUST BE FILLED IN COMPLETELY Date_____

Client's First Name_____ Last Name_____MI____
Address_____ City_____
State_____ Zip_____
Telephone (Home)_____ (Work)_____(Cell)_____
Is it OK to leave a message at home/cell? Yes___ No___
Is it OK to call you (parent/guardian) at work? Yes___ No___

Birthdate _____/_____/_____ Age _____ Gender F___ M___

Mother's Name: _____ Birthdate:_____
Mother's Place of Employment _____ Occupation:_____
Years of Schooling _____ Work Phone_____ OK to call? Y___ N___

Father's Name: _____ Birthdate: _____
Father's Place of Employment _____ Occupation_____
Years of Schooling _____ Work Phone _____ OK to call? Y___ N___

Child's legal guardian: (if not parents): _____
Legal Guardian's Address:_____

Child lives with:
Mother & Father ____ Mother ____ Father ____ Step-Parent ____ Other _____
If parents are divorced, do they have joint LEGAL custody? Y___ N___

Would you like to assign a password to this patient account? Y___ N___ Password:_____
If you are assigning a password to this account, you will be asked for this password when calling to make or confirm appointments.

Please list all others who live in the household and their ages:
Name Age Name Age

Person Responsible for Payment_____Soc. Sec. #_____

Signature of Person Responsible for Payment **X**_____

(Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship_____ Phone _____

Address_____City_____State_____Zip_____

Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

Psychiatrist_____ Phone_____

Address_____City_____ State_____ Zip_____

Other Physicians_____

Phone_____

Current Medications_____

Allergies_____

PRIMARY INSURANCE:

Patient relationship to insured (circle one): ◯Self ◯Spouse Child ◯Other_____

Insured's Name_____ Employer's Name_____
Insured's Address _____ Insurance Co/Plan_____
Insured's DOB_____ Insured's ID#_____
Insured's SSN _____ Insured's Group/Policy#_____

SECONDARY INSURANCE:

Patient relationship to insured (circle one): ◯Self ◯Spouse Child ◯Other_____

Insured's Name_____ Employer's Name_____
Insured's Address _____ Insurance Co/Plan_____
Insured's DOB_____ Insured's ID#_____
Insured's SSN _____ Insured's Group/Policy#_____

** **Please note**: If you do not provide our office with accurate insurance information at the time of service, payment for these services will be your responsibility. Please make sure to list ALL accurate insurance information.

My signature below indicates that I understand and agree with all of these statements. I certify that all information is true, accurate and complete. I agree to be personally responsible for all charges nor covered by my insurance.

Signature of Client
Or Legal Guardian: _____ Date:_____

Signature of Therapist: _____ Date:_____

CHRISTOPHER & ASSOCIATES
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PAYMENT POLICY

Agreement to Pay for Professional Services:
I have been informed of the costs of services and understand that I am responsible for the cost of services should my insurance company not cover these services. _____(initial)

I understand that if I do not provide Christopher & Associates with **all** of my insurance information, it is my responsibility to contact my insurance company for payment and that I will be responsible for payment to Christopher & Associates. _____ (initial)

I understand that Christopher & Associates will file my insurance claims as a courtesy service and authorize my insurance benefits to be paid directly to Christopher & Associates. I understand that if my insurance company does not pay my claim within 45 days, the balance will be billed to me. _____ (initial)

I am aware that some and perhaps all of the services that I receive may be non-covered services, not considered reasonable or necessary or may be excluded from my insurance plan and understand that I must pay for these services in full at the time of visit. _____ (initial)

I understand that it is my responsibility to contact my insurance company to determine my coverage of mental health services. _____ (initial)

I understand that I will attend each scheduled appointment. If I am unable to attend, I will **call to cancel the appointment within 24 hours**. I understand that I will be **charged full session fee and I will be responsible for this charge** if my appointment is not cancelled within this appropriate time frame. I also understand if I have 2 missed appointments I may not be rescheduled for at least 6 months. _____ (initial)
**This does not apply to clients with Indiana Medicaid*

All co-pays and deductibles are due at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. If you are uninsured and are receiving services, we require payment in full at time of service. _____ (initial)

Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you or your immediate family members may be discharged from this practice. _____ (initial)

My signature below indicates that I understand and agree with all of these statements:

Signature of Client:_____ Date:_____
Or Legal Guardian

Signature of Therapist:_____ Date:_____

Payment Arrangements:

☐ I give Christopher & Associates permission to charge my credit or debit card if my account has a balance over 90 days past due, including missed appointment fees.
*This information will be kept in your confidential file

Credit Card # _____ ☐ VISA ☐ MasterCard ☐ Discover
Exp Date: _____ 3 Digit code:_____

Printed Name_____ Signature:_____
Date:_____