

CHILD REGISTRATION

Name (Child) _____ Sex _____ Age _____ D.O.B. _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

School _____ Grade _____

Pediatrician/Doctor _____ Location _____

ADULTS LIVING WITH CHILD:

Name of mother/step-mother (Circle one) _____

Occupation _____ Work Phone _____
Cell Phone _____

Name of father/step-father (Circle one) _____

Occupation _____ Work Phone _____
Cell Phone _____

May we call you at home/cell (circle) to remind you of your appointment? Yes No

Name of biological parent not living with child: _____ Phone: _____

Who referred you to Dr. Cooley? _____

- I understand that I may be charged for appointments not canceled 24 hours in advance.
- I understand that I am responsible for fees for services. Outstanding balances on my account may be submitted to collections after thirty (30) days.

Parent Signature _____ Date _____

Notice to patients using insurance

To utilize your health insurance, a diagnosis of a mental disorder must be submitted to your insurance company. This may potentially affect the confidentiality of your child's treatment. In addition, this diagnosis may jeopardize his/her ability to obtain medical, life, or disability insurance in the future.

BLUE CROSS/ BLUE CHOICE INSURANCE INFORMATION

Insured's Name _____ D.O.B. _____ Phone # _____

Insured's Address _____ State _____ Zip _____

Insured's I.D./S.S. # _____ Group # _____

I authorize the release of my Protected Health Information to process my insurance claim and I authorize payment of medical benefits to Myles L. Cooley, Ph.D. for services rendered. I understand that I am responsible for fees for professional services if my insurance company fails to reimburse as expected.

Parent/Guardian Signature _____ Date _____

Office use only

Co-pay _____ Ded. Amount _____ Amt. Satisfied _____ \$/year _____ Visits: _____/year