Evan A. Mehlman, Psy.D. and Associates

Child, Adolescent, Adult Psychotherapy and Evaluation
(Child)

Welcome to our practice! We are proud to be able to serve you and your family. Our mission is to provide you with the highest quality care possible with compassion and understanding for all your needs. Psychotherapy is a collaborative relationship between the psychotherapist and patient. Our practice provides numerous services for a wide variety of clientele with various life difficulties. We pride ourselves in our knowledge of and ability to use the best possible practices for your health and well-being.

Please be aware it is important to be on time for each appointment. We feel it is essential for you to be able to receive quality care in the allotted time of each session.

If you cannot attend a scheduled appointment, kindly notify us as soon as possible. Please be aware you will be charged for any appointment that is not cancelled at least 24 hours in advance. **You will be solely responsible for the charge** of the entire session as we are unable to bill insurance for missed appointments.

Fees/co-pays will be collected at the end of every session.

Please read, fill out, and sign the following pages, including the last page of the HIPAA information for us to better serve you and your rights.

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Patient Information (Child)

Today's Date:_____ Your Appointment is with: _____

Patient Name: _____ Date of Birth:_____

Gender:_____ Age:_____ Child S.S#_____

Child's Primary Address:_____

City:_____ State:_____ Zip:_____

Home Phone: _____ Mom Cell: _____ Dad Cell:_____

Mom E-Mail:_____ Dad E-Mail:_____

School: _____ Grade:_____

Parent Information (**Mom**):

Name:_____ Date of Birth: _____

Parent/Guardian Address:_____

Apt #:_____ City:_____ State:_____ Zip:_____

Current Employer:_____ Occupation:_____

Parent Information (**Dad**):

Name:_____ Date of Birth: _____

Parent/Guardian Address:_____

Apt #:_____ City:_____ State:_____ Zip:_____

Current Employer:_____ Occupation:_____

Living in Home:	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address:_____
May I have your permission to thank this person for the referral? • Yes • No

Financial/Insurance: If you have health insurance, it may pay for a part of the cost of your treatment here. To find out if this is so, my staff and I need your information. Please provide us with a copy of your insurance card.

I understand that I am responsible for all charges, regardless of insurance coverage.

I give this office permission to release any information obtained during examinations or treatment, to my Insurance company, to support any insurance claims on this account and secure timely payments due to the Assignee or myself.

Assignment of benefits:

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

_____
Parent/Guardian's signature

_____
Date