# Schelle Miller, Ph.D.

## APPLICATION FOR SERVICES
## CHILD FORM

**Today's Date:** **Referral Source:**

**Child's Name:** **Date of Birth:** **Age:**

**Gender:** **Race/Ethnicity:**

**Highest Grade Completed:** **Name of School:**

**Daycare (if any):**

**Name of legal custodial parent(s)/guardian(s):**

Relationship

**With whom does the child live?**

**Who is the Primary Caregiver - *Primary Home* :**

Name Relationship Date of Birth Age Gender

**Primary Contact Number:** **May we leave a message?**

**Secondary Contact Number:** **May we leave a message?**

**Mailing Adress:**

**Street Address (If Different from above):**

***Email Address:***

**Highest Grade or degree Completed:** **If currently a student list school:**

**Occupation:** **No. of Years:**

**Marital Status:** **No. of previous marriages:**

**Who is the Primary Caregiver - *Second Home (if applicable)* :**

Name Relationship Date of Birth Age Gender

**Primary Contact Number:** **May we leave a message?**

**Secondary Contact Number:** **May we leave a message?**

**Mailing Address:**

**Street Address (If Different from above):**

***Email Address:***

**Highest Grade or degree Completed:** **If currently a student list school:**

**Occupation:** **No. of Years:**

**Marital Status:** **No. of previous marriages:**

**Emergency Contact:** **Rel:** **Phone Number:**

## Billing and Payment Information

**Person responsible for payment:**

**Mailing Address:**

**Primary Contact Number:** **May we leave a message?**

**Name of Insurance:** **Customer Service number:**

**Insurance Member / ID Number:** **Group Number:**

**Policy Holder's Name:** **Date of Birth:**

**Address:**

**Email:**

**PLEASE COMPLETE SECTION BELOW FOR ANY *SECONDARY* INSURANCE**

**Name of Insurance:** **Customer Service number:**

**Insurance Member / ID Number:** **Group Number:**

**Policy Holder's Name:** **Date of Birth:**

**Address:**

**Email:**

***Please notify me and my office staff if any of your contact information or insurance changes.***

**Please list others who currently live inthe home with the child:**

| *Name* | *Relationship* | *Age* | *Gender* | *Occupation* |
|---|---|---|---|---|
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**Please list other family members who do not live with the child:**

| *Name* | *Relationship* | *Age* | *Gender* | *Occupation* |
|---|---|---|---|---|
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**What is your reason for seeking therapy for the child at this time?**

**List any current or previous major health problems of the child:**

**Current Routine Medications:**

**Who is the child's Primary Care Physician?** **Phone:**

**List any Specialists the child sees:**

**Is there any family history of mental health issues?** **If so, who and what type of issue:**

**Has the child ever received counseling or mental health services before?** **If so, please list the counselor(s) or doctor(s): Name, City, Reason for Service and Approximate Dates of Service**

**Has the child ever been hospitalized for emotional or mental health reasons?** **If so, please list: Name of the hospital, City, Approximate Dates of Service and Reason for Hospitalization.**

**NOTE: Except for crisis services, only a legal custodial parent/guardian may consent for services for a minor child.**

**The information I have given in this application is acurate and complete. I have the legal right to consent for services for my child and I am freely seeking professional counseling or psychological services for my child at this time.**

**Legal Guardian/Parent Name (printed):**

**Legal Guardian/Parent Name (Signature):** **Date:**

**Effective 03/26/20**