

Cher L. King, Ph.D., Licensed Psychologist

PATIENT INFORMATION

If the patient is a minor, list his/her full legal name on the patient line.

Patient name: _____ Birth Date: _____

Age: _____ Male: _____ Female: _____ Social Security No: _____

FINANCIAL RESPONSIBILITY

PLEASE READ: The financially responsible party is the patient or, **if the patient is a minor, the financially responsible party must be a parent or legal guardian with whom the child resides at least part time, even if another person is the subscriber on the medical insurance plan that covers the patient and even if another person is presumed to be responsible for medical costs. This parent/legal guardian must be the same person who signs the Financial Agreement and Informed Consent forms and the same person who is making arrangements for the child to be seen by Dr. King.**

Responsible Party: _____ Relationship to patient: _____

Social Security No: _____ Birth Date: _____

Address: _____ City/State: _____ Zip: _____

Home Phone : _____ Cell: _____ Work Phone: _____

Employer: _____ May we call you at work? ___ Yes ___ No

*Email address : _____ (Do not list if you prefer not to receive email or if you believe email may not be sufficiently confidential.)

Spouse of Responsible Party: _____ Relationship to patient: _____

Social Security No: _____ Birth Date: _____

Employer: _____

Emergency Contact Person: _____ Phone: _____

Relationship of this person to patient: _____

Signature of responsible party

Date signed

** It is preferred that you list your personal email address and not a work email address for reasons of confidentiality. If you prefer that we not email you, please do not list your email address. If you seldom check your email and do not believe it would be an effective way to communicate, please do not list your email address.*

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE INFORMATION ON THE NEXT PAGE

Complete this page only if the patient is a minor.

Patient Name: _____ Birth Date: _____

Are you the child's: _____ biological parent _____ adoptive parent
_____ other, please describe _____

Does the child reside with you at least part time? _____ Yes _____ No

Do you have legal custody/guardianship? _____ Yes _____ No

Are you currently involved in a legal dispute concerning custody/visitation? _____ Yes _____ No

Is legal custody/guardianship of this child shared with another person who does NOT reside with you? _____ Yes _____ No

If no, skip to bottom of page, sign, and date.
If yes, provide the additional information below.

Name of person sharing legal custody/guardianship: _____

Relationship of this person to the child: _____

Person's mailing address: _____

Describe the parent time arrangements: _____

Is this person aware you are bringing this child to Dr. King for evaluation/treatment? _____ Yes _____ No

Have you been awarded the right to make medical decisions about your child regardless of the other person's wishes? _____ Yes _____ No

Are there reasons this person should not be asked to sign the *Informed Consent* form to give his/her consent for evaluation/treatment? _____ Yes _____ No

If yes, please explain. _____

My signature below certifies the above information is correct.

Signature of responsible party

Date signed