Beacon Psychology Services, LLC
Registration Form for Children/Adolescents

PATIENT INFORMATION

Patient's Name	Date of Birth	☐ Male ☐ Female
Home Address	City, State Zip	
Family Physician/Pediatrician	Physician Phone	

PARENT/GUARDIAN INFORMATION

Parent's Name				Gender	
Address (if different from patient)					
Preferred Phone	□ Mobile □ Home □ Other	Alt Phone	□ Mobile □ Home □ Other	Other Phone	□ Mobile □ Home □ Work
Spouse's name (if different from parent)					
Parent's Place of Employment		Occupation			
Parent's Name				Gender	
Address (if different from patient)					
Preferred Phone	□ Mobile □ Home □ Other	Alt Phone	□ Mobile □ Home □ Other	Other Phone	□ Mobile □ Home □ Work
Spouse's name (if different from parent)					
Parent's Place of Employment		Occupation			

CONSENT TO TREAT and PRIVACY ACKNOWLEDGEMENT

I hereby request and authorize Beacon Psychology Services, LLC (hereafter referred to as "Beacon Psychology") and its respective personnel to provide mental health services/treatment to my child/legal dependent (hereafter referred to as "child"). I understand that mental health services/treatment may include and are not limited to assessment services including tests and procedures as well as therapeutic treatments, and that I am agreeing only to those services that Beacon Psychology is qualified to provide within the scope of the provider'(s) license, certification, and training or the scope of license, certification, and training of those provider'(s) directly supervising the services received by my child or me. I understand that with this consent, I give permission for aspects of my child's private healthcare information to be shared with Beacon Psychology, as is necessary for services to be provided. I understand that these services do not come with guarantees, that no guarantees have been given to me by Beacon Psychology, and that certain risks may be present in my child's participation in these services. I also understand that, at any time, I can terminate this consent for treatment for my child by putting such request in writing.

I understand that communications within Beacon Psychology will be confidential. I understand that there are special circumstances that will require Beacon Psychology to break that confidentiality. By law, Beacon Psychology must report actual or suspected child or elder abuse to the appropriate authorities. In addition, Beacon Psychology is legally bound to take appropriate action if my child or I threaten anyone with violence, harm, or dangerous actions. I am aware that I can ask further questions about confidentiality with any personnel.

I hereby acknowledge that I have been offered a copy of the 'Notice of Privacy Policies' and understand the information included in this document. I am aware that a copy of this notice will be given to me when I ask for a copy.

_____ _____

Parent/Guardian signature Date signed

[Continued on reverse]

FINANCIAL AGREEMENT

I agree to pay in full, at the time of service, for all services rendered on my child's behalf by Beacon Psychology. I understand that Beacon Psychology will provide me with a billing statement that I can file with my insurance provider for reimbursement if I choose not to use my insurance benefits or if Beacon Psychology is not a participating provider with my insurance plan. I understand that if Beacon Psychology is a participating provider with my insurance company that I will pay the full co-pay at time of service and that Beacon Psychology will submit a claim to my insurance provider. I understand that if my child has Medicaid, Medicare, or Tricare coverage, services provided at this office are non-Medicaid, Medicare, or Tricare reimbursable, and that I assume full financial responsibility for all services rendered.

I agree to provide accurate and updated healthcare/insurance information to Beacon Psychology to assist in financial reimbursement from healthcare insurance for services provided. I hereby give consent to Beacon Psychology to release any required information to my healthcare insurance to assist in the processing of claims, including protected healthcare information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). I acknowledge and understand that I am responsible for all charges not paid by insurance benefits, in accordance with applicable laws and regulations.

I understand that 24 hours notice of cancellation is required to avoid charges for missed appointments. I am aware that I may be charged a late fee if I arrive more than 15 minutes late for my child's appointment, and that late charges as well as missed appointments are not covered by insurance plans.

I understand that in families where parents do not share the same household, payment for services is the responsibility of the parent who accompanies the child to the appointment regardless of any court orders regarding payment. I understand that if this account is subject to collection, I will be responsible for all collection costs and fees, including but not limited to court costs and attorney fees.

I understand and agree to pay for any services related to legal matters, including but not limited to depositions, attorney phone calls, and court testimony; these services are a different pay rate.

_____ _____

Parent/Guardian signature Date signed

CONSENT FOR COMMUNICATIONS

I hereby agree to allow Beacon Psychology to call my home or cell phone number to reach me for appointment reminders, appointment changes, or other information related to my services at Beacon Psychology. If there is a number that I do not wish to have Beacon Psychology contact me at or a different number than the home or cell phone at which I desire to be contacted, I agree that it is my responsibility to inform Beacon of this fact.

By listing my email address below, I hereby agree to sending to and receiving from Beacon Psychology email communications as part of comprehensive treatment for my child. I understand the risks of sending PHI through email even with encryption, and with this agreement I am accepting these risks to my child's PHI. *I understand that if I request communications from the practice be delivered to me by email, this form of communication may not be secure, creating a risk of improper disclosure to unauthorized Individuals. I am willing to accept that risk and will not hold the practice responsible should such incident occur.* I accept that Beacon Psychology shall not be held responsible for any exposure of email communications at my home or place of employment, depending on the location of my email address. I also understand that email communications can fail in their transmission, and I agree to contact Beacon Psychology if I have not obtained a response from my email communication within three business days. I also agree to never use email communications for emergency situations, and to call the office directly with any emergencies. I understand that I can terminate this agreement at any time by informing Beacon Psychology in writing. With my signature, I believe that the benefits of using email communications for my child's healthcare outweigh the security risks.

_____ _____

Parent/Guardian signature Date signed

Preferred email address: _____