GULF COAST PSYCHOLOGY

5290 SUMMERLIN COMMONS WAY, SUITE 1002
FORT MYERS, FLORIDA 33907
PHONE: 239-274-7792
FAX: 239-247-5344

Child Patient Information Form

Patient Name:_____ **Today's Date:**_____

DOB:_____ **Age:**_____ **SSN:**_____-_____-_____ **School/Grade:** _____

Patient's Primary Home Address:_____ **City/State:**_____ **Zip:**_____

Parent 1: _____ **DOB:**_____ **SSN:**_____-_____-_____

Address: _____ **City/State:**_____ **Zip:**_____

Phone: _____ **Email:** _____

Parent 2: _____ **DOB:**_____ **SSN:**_____-_____-_____

Address: _____ **City/State:**_____ **Zip:**_____

Phone: _____ **Email:** _____

Emergency Contact Number:_____ **Relation to patient:**_____

Reason for requesting appointment:_____

Approximate date or time problem began:_____ **Previous Therapy or Counseling:**_____

Is child currently taking any medications: Yes or **No** **Referred by:** _____

The person who initiates treatment is financially responsible for payment. I agree to pay for all charges not reimbursed by my insurance or not reimbursed by any other payment source, including deductibles and copayments.

Parent/Guardian Signature: _____ **Date:**_____

I was provided a copy of the Notice of Privacy Practices for review. Please sign and print your name and date below, acknowledging that you have read and understand the Privacy Practices.

Print Name: _____ **Signature:**_____ **Date:**_____

I understand that text message, email and phone call reminders are a courtesy, and it is my responsibility to remember my appointments. I also understand that I will be charged a missed appointment fee if cancellation takes place less than 24 hours before my scheduled appointment time.

Parent/Guardian Signature: _____ **Date:**_____