



CHILD GUIDANCE CENTER

Helping kids find hope and healing

APPLICATION

Child's legal name _____

_____ First MI Last
Social Security Number _____ Date of Birth _____ Age _____ Sex _____

Parent's name _____ Age _____ Place of Employment _____

Parent's name _____ Age _____ Place of Employment _____

Legal guardian(s) (if different from above) _____

Address _____ City _____

County _____ State _____ Zip Code _____

Home phone _____ Work phone (mother) _____ (father) _____

Race (please check): Black/African-American _____ White/Caucasian _____ Amer. Indian _____ Asian/Pacific Islander _____ Alaskan Native _____ Other _____

Ethnicity (please check): Mexican _____ Puerto Rican _____ Cuban _____ Other Hispanic _____ Not of Hispanic origin _____

Citizenship Status: U.S. Citizen _____ Visa _____ Green Card _____

FINANCIAL INFORMATION

Fees are based upon a sliding scale determined by the family's ability to pay. The information below enables us to set a fair figure.

*Total family income _____ *Family size _____

(Including all wages, child support, alimony, ADC, social security and disability)

Comments: _____

INSURANCE INFORMATION (if applicable)

Name of company _____ ID Number _____ Group Number _____

Parent's name that carries insurance _____

Date of Birth _____ Social Security Number _____

MEDICAID INFORMATION (if applicable)

Blue Card Number _____ Child's ID _____

To be filled out at the agency with a staff member from the Business Office.

Fee based on income _____ Actual Fees _____ Insurance Co-Pay _____

Conners Testing Fee _____ Ph.D. fee _____

All insurance companies, including Medicaid, will be billed at our Full Fees. Full Fees are \$190.00 for the initial session, \$97.00 for individual/family sessions, \$31.00 for group sessions, and \$48.50 for .5 hrs for Conners Testing. Clients who have insurance coverage will be held responsible for their Actual Fees instead of their co-pay as allowed by insurance when the insurance company denies coverage of a charge.

Payments will be made: At the time of Service _____ Weekly _____ Bi-Weekly _____ Monthly _____ N/A _____. If payments are not made as agreed, payment at time of services will be required.

MSE-Scheduled _____ With Dr. _____

Family income was verified by: Income Tax Form _____ W-1 _____ Paycheck Records _____ Self Report _____

*My signature verifies that the income stated is accurate: Parent Signature: _____

If insurance coverage exists, I authorize payment of medical benefits to Child Guidance Center. If I receive the check from the insurance company, I will bring that check into Child Guidance. I understand if I fail to do so, I will be responsible for the amount of the check. I understand that it is my responsibility to notify Child Guidance of any changes in my Medicaid or insurance coverage and/or financial status. If I fail to inform Child Guidance of changes and that results in reduced or non-payment by my insurance company, it is my responsibility to pay the full fees for the effected dates of services. Medicaid clients will not be charged, but may be reported to Medicaid for their failure to report such changes.

Signature of Parent or Guardian (Payer) _____ Date _____ Staff Signature _____ Date _____