

**Northland Counseling Center, Inc.
Minor Registration Form**

Client Name: _____ Client Number: _____

I. ADMISSION INFORMATION

Client Address: _____

City _____ State _____ Zip _____

Phone #: (home) _____ (work) _____ (cell) _____

I authorize Northland staff to contact me at the above address and phone number: Yes No

May we leave a message if you are not at home? Yes No

Birthdate: _____ Social Security #: _____ Sex: Male Female

Client's primary physician: _____

II. MINOR INFORMATION *(Signature on reverse authorizes treatment of above client)*

Parents in household: Mother _____ Father _____

What type of custody do you retain? (check all that apply)

Full legal custody

Physical custody

Joint legal custody

Custody not yet determined

Other (please specify) _____

If joint custody or none of the above, please list name, address and phone number of other party retaining custody:

(Northland is required to obtain consent to treat this minor from the above named person)

III. INSURANCE INFORMATION *(check and complete all that apply)*

Primary insurance *(attach copy of card)* ID# _____ Group# _____

Insurance Company Name _____

Address _____

Phone Number _____

Subscriber Name _____ DOB: _____

Address _____

Relationship _____

Secondary Insurance *(attach copy of card)* ID# _____ Group# _____

Insurance Company Name _____

Address _____

Phone Number _____

Subscriber Name _____ DOB: _____

Address _____

Relationship _____

No insurance Have you applied for Medical Assistance? Yes No Pending or denied?

****PLEASE READ AND SIGN REVERSE****

IV. RELEASE OF INFORMATION

I authorize Northland Counseling Center, Inc. to release information to my insurance company regarding my treatment and I permit a facsimile or photographic reproduction of this authorization in place of the original. This could include my Social Security number, diagnosis, prognosis, dates of treatment, narrative notes, and types of treatment. This is for the purpose of validating claims submitted to stated insurance carrier. I also authorize stated insurance carrier to make payments to Northland Counseling Center, Inc. for all insurance benefits to which I or my dependents are entitled for services received. I understand that this consent will terminate one year from signature date unless I choose to revoke it earlier.

V. STATEMENT OF UNDERSTANDING

I understand that I am responsible for the charges in full if I do not maintain coverage for which I am eligible or fail to provide insurance information and/or income verification (if interested in fee reduction).

I recognize that Northland Counseling Center, Inc. cannot guarantee payment of charges by any particular insurance carrier. **If I have questions regarding coverage, I will contact my insurance company.**

In the event Northland Counseling Center, Inc. has been unable to collect payment from me for services within a reasonable period of time, the Center then reserves the right to turn the account over for collection of my bill. A 15% processing fee will be added to any account sent to collections.

I affirm that the information on reverse is accurate. I am aware of my financial responsibilities and agree to the payment terms. I authorize the release of information to my insurance carrier(s). **If my address, phone number, financial status, or insurance coverage changes, I will notify Northland Counseling Center, Inc., and an update of this agreement may be renegotiated.**

Client signature

Date

Parent/Guardian signature

Date

NORTHLAND COUNSELING CENTER
215 SE 2nd Avenue, Grand Rapids, MN 55744
(218)326-1274 / Fax (218) 326-9787

Authorization For Treatment Of A Minor

Name _____ DOB _____

_____ I authorize NORTHLAND COUNSELING CENTER and its staff to administer services and/or treatment to my child.

_____ I authorize NORTHLAND COUNSELING CENTER and its staff to administer services and/or treatment to my ward.

What type of custody do you retain?

- Full legal custody _____
- Joint legal custody _____
- Physical custody _____
- Other (please specify) _____

If none of above, give name, address and phone of person with custody

Responsible Party Print Name _____

Responsible Party Signature _____ Date _____

By signing this form I agree that all of the above statements are true and accurate.

**HEALTH QUESTIONNAIRE
(Clients 18 years and younger)**

Northland Counseling Center, Inc.

215 Southeast Second Ave., Grand Rapids, MN 55744
Phone: 218-326-1274

Please complete the information below on the front and back of this form. Once completed, please give to the receptionist. Thank you.

Client's Name: _____
 First **Middle** **Last**

Date of Birth: _____ Age _____ Weight _____ Height _____
 (mm/dd/yyyy)

Sex of the Patient: Female _____ Male _____ Other _____

Names of Parents/Guardians: _____

Name/Relationship of Person Completing this Form: _____

Name of current school/program: _____

School grade: _____ IEP/504 plan? If yes, please explain: _____

Primary Care Physician's Name and Clinic: _____


Please state last appointment with a Primary Care Physician: _____

Preferred Pharmacy: _____

Are you currently being treated for any illness? If yes please explain:

Do you have any medical and/or surgical history? If yes please explain:

Are you currently taking any medications? If yes, please list name of medication and dose:

Turn Over To Complete Other Side 

Please list all allergies and medication side effects: _____

Do you, or anyone in your family, have a history of thyroid disorder ___ Yes ___ No. If yes please explain: _____

History of head trauma: _____ Yes _____ No History of fractures: _____ Yes _____ No

If you answered yes to any of these, please explain: _____

SUBSTANCE USE AND ABUSE:

Tobacco/Nicotine _____ Caffeine _____ Alcohol _____ Marijuana _____ Cocaine/Crack _____
Spice _____ Heroin _____ Hallucinogens _____ Methamphetamines _____ Benzodiazepines _____
Inhalants _____ Ecstasy _____ Other: _____

If yes to any of the above, please state time of use and amount used: _____

BEHAVIORAL HEALTH INFORMATION:

Please list current/previous behavioral health diagnosis: _____

Please list current/previous behavioral health treatment (Including chemical dependency treatment):

___ Inpatient Dates _____ Facility _____ Location _____

___ Outpatient Dates _____ Facility _____ Location _____

___ Therapy Dates _____ Facility _____ Location _____

___ Psychiatrist Dates _____ Facility _____ Location _____

Briefly describe your reason for consultation today: _____

How long has this been a problem for you? _____

Please list current symptoms: _____

Please provide additional information you feel is important: _____

Strengths and Difficulties Questionnaire

P or T⁴⁻¹⁰

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of the child's behavior over the last six months or this school year.

Child's name

Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children, for example toys, treats, pencils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, prefers to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often offers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees work through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Parent / Teacher / Other (Please specify):

Thank you very much for your help

Authorization for the Release of Medical Information

I, _____ authorize
(Name) (DOB)

Northland Counseling Center to:
(Check one or both)

Give information to
 Receive information from

(Outside Agency or Individual's Name)

Dates or Type of service to be released by mail, telephone, or facsimile as follows:

<input checked="" type="checkbox"/> Diagnostic Assessment/Psychological Evaluation	<input checked="" type="checkbox"/> Psychological Testing Results
<input checked="" type="checkbox"/> Treatment Plan	<input checked="" type="checkbox"/> Medical Report and Medication Regimen
<input checked="" type="checkbox"/> Narratives/Progress Notes	<input checked="" type="checkbox"/> Discharge Summary
<input checked="" type="checkbox"/> Educational Information	
<input checked="" type="checkbox"/> Other (specify) _____ Verbal	

Records related to chemical dependency, mental health, sickle cell anemia, tuberculosis, and/or HIV/AIDS will be released, unless otherwise indicated by initialing here: _____

Approximate Dates of information requested: _____ Current or most recent episode of care.

Purpose of Disclosure:

<input checked="" type="checkbox"/> Coordination of Care and Services	<input type="checkbox"/> Legal
<input checked="" type="checkbox"/> Future Referrals/References	<input type="checkbox"/> Disability Claims
<input type="checkbox"/> Other (specify) _____	

I understand that my authorization terminates one year from the date of my signature. I understand that I have the right to revoke this authorization in writing at any time prior to the termination date. I understand that NCC cannot release information disclosed by this authorization to anyone other than listed above, and that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient only upon my written consent. I further understand that the information disclosed as a result of this authorization may no longer be protected and could be redisclosed by the recipient without my permission. NCC will not condition treatment on my signing this authorization. A copy of this authorization shall be considered as valid as the original.

Client/Guardian Signature

Date

If signing as the authorized representative of the patient, I am: (please check one)

Court appointed guardian
 Custodial parent of a minor
 Other, explain _____

Witness

Date

This information will be disclosed from your records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical, or other information, is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.