

## CHILD FACE SHEET

**Child's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Town/City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Phone #** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

**Who referred you to our clinic?** \_\_\_\_\_

**Child resides with:** \_\_\_\_\_

**Mother/Guardian Name:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**SS#** \_\_\_\_\_ **Business/Cell Phone:** \_\_\_\_\_

**Father/Guardian Name** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**SS#:** \_\_\_\_\_ **Business/Cell Phone:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ **ID#:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Group Name:** \_\_\_\_\_ **Policy Holder:** \_\_\_\_\_

**Policy Holder's Date of Birth:** \_\_\_\_\_ **Policy Holder SS#** \_\_\_\_\_

### CONSENT TO THE USE AND DISCLOSURE OF PATIENT HEALTH INFORMATION FOR TREATMENT, PAYMENT, RESEARCH AND HEALTHCARE OPERATIONS

I understand that my health information may be used and disclosed by NC Neuropsychiatry to carry out treatment, to obtain payment, and to conduct healthcare operations. I understand that NC Neuropsychiatry has a Privacy Policy, which gives a more complete description of uses and disclosures of health information, and which is freely available for me to read. I hereby grant medical personnel of NC Neuropsychiatry permission to release health information acquired in the course of my examination and treatment to the appropriate parties, with all due discretion, when necessary for treatment, payment, healthcare operations and emergency purposes. Examples of my health information that may be released include clinical findings, diagnosis, assessment, laboratory results, progress notes, psychotherapy notes, treatment recommendations, names of health care personnel, dates of hospitalizations, charges, visits, and any other information that may be related to medical and psychiatric conditions, including drug and alcohol related problems and sexually transmitted diseases. I understand that medical personnel at NC Neuropsychiatry will communicate, on a regular basis, with other treating health care providers. All records are kept confidential and shared only with pertinent personnel involved.

I understand that I may fill out rating scales and take psychological tests, including computerized tests, as part of a routine or special evaluation. I have been informed that the data from these instruments may be used for the purpose of research; for example, to evaluate the reliability of a test, or to assess the cognitive effects of different medications. My identity, however, is detached from these data before they are ever used, and can never be discovered or revealed.

I understand that I have the right to request restrictions on how health information may be used or disclosed, but that the provider designated is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the provider has taken action in reliance on the consent. I agree that this consent shall be valid for the duration of my treatment at NC Neuropsychiatry or until rescinded in writing.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_