



# Shannon E. Taylor PhD



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## Child and Adolescent Patient Information

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Gender : \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email Address: \_\_\_\_\_

Referred by: \_\_\_\_\_

Does the child live in the home with both of his or her biological parents? \_\_\_\_\_

If not, who is the child's primary caregiver? \_\_\_\_\_

For How Long? \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

What are the Custody or Guardianship Arrangements? \_\_\_\_\_

*Please provide documentation of custody or guardianship arrangements as applicable*

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Occupation: \_\_\_\_\_

Place of Business: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Occupation: \_\_\_\_\_

## Information Regarding Payment for Services

*Payment for requested services is due on or before the date services are rendered, as described in our financial agreement. If you like, we will contact your insurance company to inquire about your out-of-network benefits and to submit your claim. We will estimate your co-payment based on the information provided by your insurance company, including their statements regarding your deductible and coverage. Please be aware that there is no guarantee that your insurance company will cover the service(s), even if they initially say they will do so. It has been our experience that insurance companies sometimes deny or reduce coverage based on the terms of your particular plan, the diagnosis, and/or their beliefs about whether the service is medically necessary. Their beliefs may differ from your beliefs or those of the referring physician.*

*If you would like for us to contact your insurance company to inquire about benefits and/or to file your claim, please provide the following information:*

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

I have provided accurate information relevant to my child and relevant custody issues. I have read and understand the above information regarding insurance coverage and would like to proceed with the requested services.

Signature of Parent or Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_