

Ψ Lifetime Development

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BACKGROUND INFORMATION FORM - CHILD

	Patient:	Mother	Father
Name			
D.O.B			
Age			
Occupation			
Marital Status or Sex:			
Tel. #1			
Tel. #2			
Fax:			
e-mail:			
Home Address			
School or Employer			
School or Work Address			
Driver's License #			
SS #			
Insurance Company			

FEES CHARGED: Unless other specific arrangements are made, I will pay the agreed fee at each session or provide a credit card for weekly or monthly charges. A termination consultation is required, and this is paid for at the beginning of the treatment.

I understand that I am responsible for 50% of ordinary charges for cancellations, including for illness, that are made within less than 24 hours and which cannot otherwise be filled.

CONSENT TO RELEASE INFORMATION: If you wish for us to communicate with others in regard to the start of treatment, we must have your signature provided below. This is a legal requirement regarding release of information to third parties.

NAME	TELEPHONE	E-MAIL/FAX

_____ Date _____
Signature of Responsible Party (required):