

Merrimack Valley Counseling Association  
39 Simon St., Unit 2A  
Nashua, NH 03060

**Minor Child Information Sheet**

**\*\*\* Please print this form, complete it and bring it with you to your first scheduled appointment. To protect the confidentiality of your health information, please do not e-mail this. \*\*\***

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City, ST, Zip \_\_\_\_\_  
Tel. No: \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C)  
Parent(s) Name: \_\_\_\_\_  
Who does the child reside with? \_\_\_\_\_  
School Name and Telephone Number: \_\_\_\_\_

**Non-custodial parent information, if applicable:**

Does the non-custodial parent have a legal right to approve or disapprove treatment for their child? Yes No  
If yes, does he/she approve the treatment that will be rendered by  
Merrimack Valley Counseling Assoc.? Yes No

***If no, we will be unable to provide services until both parents agree to treatment.***

If yes, please have the non-custodial parent complete the following:

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

My signature below indicates my agreement with treatment provided by Merrimack Valley Counseling Association for my child \_\_\_\_\_. I understand that I may revoke this authorization, in writing, at any time.

\_\_\_\_\_  
Non-Custodial Parent Signature

\_\_\_\_\_  
Date

**Primary Insurance Subscriber Information:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_ Employer: \_\_\_\_\_

**Secondary Insurance Subscriber Information:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_ Employer: \_\_\_\_\_

**Emergency Contact Information:**

Name: \_\_\_\_\_ Tel No \_\_\_\_\_ Relation \_\_\_\_\_

**Current Primary Care Physician:**

Name: \_\_\_\_\_ Tel. No. \_\_\_\_\_  
Address: \_\_\_\_\_

**Medical Conditions:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Pregnancy, Birth and Development:**

Were there any problems during pregnancy?

Were there any problems at the time of birth or during the post-natal period?

Did development occur within normal limits?

Please summarize your reason(s) for seeking counseling:

**Statement of Confidentiality:**

Within certain limitations, information by you and (if applicable) your child(ren) during the course of treatment will be kept strictly confidential and will not be revealed to any other person and/or agency without your written consent. At your request, any or all parts of your records can be released to any person and/or agency you designate in writing. There are certain situations in which Psychologists, mental health professionals and/or medical professionals are required by law to reveal information without your permission. These include:

1. Clear suspicion that physical abuse, sexual abuse or physical neglect has occurred to a minor.
2. Grave bodily harm or death is threatened to another person
3. Serious suicidal intentions are conveyed and a client or their guardian refuses voluntary treatment to ensure the patient's safety
4. When a court of law issues a subpoena for information obtained during treatment in response to the order of a court of law
5. Reporting as mandated by HIPPA, The Health Insurance Portability and Accountability Act.

If you have questions and/or concerns regarding your rights to confidentiality, please discuss them with your mental health professional at the time of your appointment.

**Medical and Payment Authorization/Assignment of Payment/Promise to Pay**

I have read the cancellation policy and understand that except in extraordinary circumstances, missed appointments and those canceled without 24 hours notice will be billed directly to me at the full session rate. I also understand that insurance does not cover fees for missed appointments.

I also authorize my mental health provider or the health care vendor providing services or benefits to release any mental health, substance abuse assessments or medical treatment information necessary to effect treatment or claim payments to Merrimack Valley Counseling Association .

I authorize payment of benefits to Merrimack Valley Counseling Association for services rendered, providing other arrangements have not been previously negotiated. I also understand that I am responsible for any services and/or fees that are not covered by my insurance company.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

I certify that the information I provided is accurate and I understand the above Statement of Confidentiality.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relation to patient