Richard L. Benson, Ph.D., P.A.
Licensed Psychologist
5750 West 95th Street, Suite 320
Overland Park, KS 66207
Phone 913/596-8808 Fax 913/242-7358
www.bensonpsyc.com

CHILD/ADOLESCENT NEW PATIENT FORM

Patient Name: _____ **Date of Birth:** _____ **Age** _____
Gender: Female Male
Name(s) of Parent(s): _____ **Relationship to Patient:** _____
Address: _____
Cell: _____ **Work:** _____ **Email:** _____
Name: _____ **Relationship to Patient:** _____
Address: _____
Cell: _____ **Work:** _____ **Email:** _____
Name: _____ **Relationship to Patient:** _____
Address: _____
Cell: _____ **Work:** _____ **Email:** _____
Name: _____ **Relationship to Patient:** _____
Address: _____
Cell: _____ **Work:** _____ **Email:** _____

If parents are divorced, how does child/adolescent split time between households?

_____

Age of child/adolescent when parents separated? _____ **divorced?** _____
Age of child/adolescent when parents remarried? **Mother** _____ **Father** _____

Current Grade _____ **School Attending** _____ **District** _____
IEP? **Current** **Past** **504 Plan?** **Current** **Past**
Previous Schools Attended: _____

Medical Issues Currently Being Treated for: _____
By: provide contact info: _____
In past treated for: _____
By: provide contact info: _____

Medications:
Name _____ **Dosage/Frequency** _____ **By** _____
Name _____ **Dosage/Frequency** _____ **By** _____
Name _____ **Dosage/Frequency** _____ **By** _____

Purpose of seeing Dr. Benson: _____

Referred By: _____

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Signature/Acceptance Page

Please initial and date all applicable statements below:	**Initial**	**Date**
I agree that all charges incurred by me or my dependent(s) are my responsibility to pay (unless some other written authorization has been obtained).	_____	_____
I understand that 24 hours notice (1 business day: Friday if appointment is on a Monday, or the business day prior to a holiday if appointment is the day following a holiday) must be given if an appointment must be cancelled to avoid being charged the full fee for the appointment.	_____	_____
I assign payment of insurance benefits to this office. I understand that I am completely responsible for any penalties, denials, or disputes of non-payment for services by my insurance company.	_____	_____
I authorize the release of any medical or other information necessary in order to process my insurance claims.	_____	_____

I have reviewed all the information on the New Patient Form and, to the best of my knowledge, it is correct and complete. I acknowledge that I have been given access to Dr. Benson's Psychotherapist-Patient Services Agreement and the HIPAA Notice Form (on his website at www.bensonpsyc.com) and agree to abide by their terms.

_____
Printed Name of Patient (Parent if Patient is a Minor)

_____ _____
Signature of Patient (Parent if Patient is a Minor) Date