

### CLIENT INFORMATION (for Minor)

DATE: \_\_\_\_\_

**CLIENT:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Child's Phone (if applicable): \_\_\_\_\_ email \_\_\_\_\_

Child's Age: \_\_\_\_\_ DOB: \_\_\_\_\_ School/Employment: \_\_\_\_\_

**PARENTS:**

**A) Parent Name:** Last \_\_\_\_\_ First \_\_\_\_\_

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

Phone: \_\_\_\_\_ email: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Employment/occupation: \_\_\_\_\_

Education (# of years): \_\_\_\_\_

**B) Parent Name:** Last \_\_\_\_\_ First \_\_\_\_\_

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

Phone: \_\_\_\_\_ email: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Employment/occupation: \_\_\_\_\_

Education (# of years): \_\_\_\_\_

Referred By: \_\_\_\_\_

Current Parenting Time Arrangement (if applicable): \_\_\_\_\_

**IF COURT ORDERED:**

Name of Court (County): \_\_\_\_\_

Name of Judge/Magistrate: \_\_\_\_\_

Case No.: \_\_\_\_\_ Next Hearing Date, if any: \_\_\_\_\_

Date of Temporary Orders: \_\_\_\_\_ Date of Permanent Orders: \_\_\_\_\_

Other Court-Ordered Professionals Involved:

\_\_\_\_\_  
\_\_\_\_\_

Attorney for Parent A:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ email: \_\_\_\_\_

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

Attorney for Parent B:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ email: \_\_\_\_\_

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

Check if any of the following have ever occurred:

- Domestic violence
- Domestic violence charges filed with the police
- Child abuse allegations or charges
- Child abuse investigation by the Dept. of Social Services or other entity
- Substance abuse by either parent (alcohol or drug)
- Protection Order (filed by \_\_\_\_\_)
- Developmental or genetic problems of your child
- Other trauma to your child
- Any other significant information that Dr. Bresnick needs to be aware of (please list):

**PAYMENT TERMS AND AGREEMENT:**

1. I understand that payment for charges is due on the date of service.
2. I understand that if I cancel an appointment with less than 24 hours notice, I will be responsible for half the session fee. If I do not keep an appointment and do not notify Dr. Bresnick, I will be responsible for the total amount of the session fee.
3. I will keep my account current as to charges for which I am responsible. I understand that a \$5.00 charge will be assessed on balances that have not been paid within 45 days. I understand that after 45 days, the \$5.00 charge will be assessed on a monthly basis. If the balance due becomes older than 60 days, Dr. Bresnick is entitled to take action necessary to collect such charges, and I will be responsible for all fees and costs incurred as a result of such collection.

Signature: \_\_\_\_\_

(Person Responsible for Payment)

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

Printed Name: \_\_\_\_\_