Richard L. Benson, Ph.D., P.A.
Licensed Psychologist
7111 West 151st Street, Suite 286
Overland Park, KS 66223
Phone 913/596-8808 Fax 913/897-7487
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: ______________________

Richard L. Benson, Ph.D., P.A.
Licensed Psychologist
7111 West 151st Street, Suite 286
Overland Park, KS 66223
Phone 913/596-8808 Fax 913/897-7487
www.bensonpsyc.com

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