NEW GROWTH
COUNSELING SERVICES
CHILD REGISTRATION

430 E Lauridsen Blvd.
Port Angeles, WA 98362
360-457-1610

502 S Still Rd, Ste 102
Sequim, WA 98382
360-457-1610

Please Print

Today's Date __________________

Name of Child
____**Gender**________________________

Child's Birthdate ________________ **Age** ____ **Referred by:** _________________________________

Name of Parent(s) Seeking Therapy Services ____
Relationship: Bio Mom ____ **Bio Dad**____ **Stepmom**____ **Stepdad**____ **Other**_____________________
*Please note that the parent or guardian **seeking services** for the child is considered the responsible party. No "split billings" or copies of billings.*
Child's Current Living Situation

Mailing Address ____

Best Contact Phone Numbers for Parents/Guardians: ____

Name(s) ____

Phone ________________**Work phone** ________________**Cell** _______________**Email**_________________

Emergency Contact _____________________ **Relationship** _________________ **Phone** ____________

Name and Relationship of Parent(s)/Guardian(s) With Visitation ___________________________________

Physician ________________________ **Current Medications** ______________________________________

School/Preschool/Daycare __________________________________ **Current Grade** ______________

Current Teacher (K-8th grade) ____

Counselor (high school) ____
•Please call your insurance co. to see if authorization is needed prior to your first visit with our office.
•If a service is provided without authorization and one is needed, you will be responsible for payment.
•Many ins. policies limit the number of mental health sessions, types of services and diagnoses they cover.
•It is your responsibility to monitor payment by insurance to ensure timely reimbursement to New Growth.

A copy of the front and back of your insurance card is required. The business office will be happy to make a copy if one is not provided.

Name of Insurance Co. ____

Name of Subscriber____ **Date of Birth** ____________________

Subscriber's Insurance ID No. ___________________________________ **Group No.** _____________________

Client's Relationship to Subscriber ___**self** ___**spouse** ___**child**