BRYN DUNGAN, PSYD, HSPP
Clinical Psychologist

2680 E Main Street, Suite 304
Plainfield, IN 46168
Tel: (317) 384-7196
Fax: (317) 203-7353

CHILD REGISTRATION AND HISTORY FORM FOR TESTING

Name: Date of Birth: Age: Today's Date:

Gender: Preferred Gender Pronouns (if applicable):

Street Address: City, State, Zip

Preferred Phone Number: Email Address:

Doctor's Name and Phone Number:

Past Therapist Name and Phone Number:

Parent/Guardian Information

Parent/Guardian Name Parent/Guardian relationship to the child

Preferred Phone Number Email Address

Address

Parent/Guardian Name Parent/Guardian relationship to the child

Preferred Phone Number Email Address

Address

Insurance and Payment Information

Insurance

Insurance Phone Number

Policy holder's name

Policy holder's date of birth

Insurance ID

Group Number

Referral Information

Reason for referral

Presenting problems

How long has your child been dealing with these problems?

List Current Medications your child is prescribed and taking

Please list any other important information

Please indicate if your child has experienced any of the following:

Problems with eating	Difficulty sitting still	Difficulty paying attention or focusing
Temper problems	Disorganization	Repetitive or compulsive behaviors
Self-injury	Suicidal thoughts	Poor Social skills
Social withdrawal	Suicide attempts	Defiance or lying
Shyness	Sexual acting out	Excessive rule breaking
Problems with sleep	Difficulty completing work	
Excessive fears	Problems with drugs or alcohol	

General History

Describe your child's life through the 8th grade. Include as much as you know, including how your child was as an infant, how they got along with others, things they liked to do and any problems.

Describe your child's adolescence. Include what they have been like, their relationships, things they like to do and any problems.

Family History

Describe your child's relationship with family both currently and in the past.

Please indicate if any family member (blood relative) has or had problems in any of the following areas:

Mental Retardation	Autism	Behavior Problems
Learning Disability/Attention problems	Problems completing school	Strong temper
Anxiety, worry, panic	Obsessions or compulsions	Hallucinations or delusions
Depression	Alcohol or drug problems	Bipolar symptoms
Suicide attempts or completed	Trouble with the law	

Educational History

What is the highest level of education your child has completed? Include schools and diplomas, and certificates.

Describe any academic or behavioral problems your child experienced at school.

Social History

Describe any friends your child has. Are they supportive?

Is your child dating or in a committed relationship? If yes, please describe it.

What does your child do for fun?

Work History

Please describe your child's work history. Include their current job and how long they have been there.

Has your child ever been fired from a job? If yes, what were the circumstances?

Medical History

Does your child have any medical conditions? Have they had any surgeries?

Has your child ever been hospitalized?

Please indicate which of the following your child is using currently or have used in the past.

Currently	Past
Alcohol	Alcohol
Marijuana	Marijuana
Cocaine	Cocaine
Heroin	Heroin
Methamphetamine	Methamphetamine
LSD	LSD
Ecstasy	Ecstasy

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Practice Agreement

Initial I have received/read the Office Polices and Patient Agreement that was emailed to me and I agree to it's terms. I have also received the HIPAA Notice of Privacy Practices.

Initial I authorize the release of any information required in the course of examination or treatment necessary to process an insurance claim, if I am using insurance. I also assign payment of insurance benefits to Dr. Dungan for the services rendered.

Initial I understand and agree that regardless of any insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that if collection proceedings are necessary, I will pay all fees with collecting the bill.

Initial I understand that payment is due at the time of services unless other arrangements are made. No-show or cancellations within 24 hours of appointment time may result in a self-pay charge that will not be covered by insurance.

Initial I have read and agree to the terms of the Practice Agreement. I acknowledge that I am the Parent or Legal Guardian of the patient, and agree that my initials and signature at the end of this document is a legally binding equivalent of my handwritten signature.

Telepsychology Practice Agreement

Initial I have received/read the Office Polices and Patient Agreement for Telepsychology services that was emailed to me and I agree to it's terms. I have also received the HIPAA Notice of Privacy Practices.

Initial I authorize the release of any information required in the course of examination or treatment necessary to process an insurance claim, if I am using insurance. I also assign payment of insurance benefits to Dr. Dungan for the services rendered.

Initial I understand and agree that regardless of any insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that if collection proceedings are necessary, I will pay all fees with collecting the bill.

Initial I understand that payment is due at the time of services unless other arrangements are made. No-show or cancellations within 24 hours of appointment time may result in a self-pay charge that will not be covered by insurance.

Initial I have read and agree to the terms of the Practice Agreement for Telepsychology services. I acknowledge that I am the Parent or Legal Guardian of the patient, and agree that my initials and signature at the end of this document is a legally binding equivalent of my handwritten signature.

Revised Supplemental Informed Consent for In-Office Visits During the Pandemic

I understand and agree to the following requirements to be seen during the pandemic:

Initial You will wear a cloth face covering or surgical face mask during all sessions and Dr. Dungan will do the same.

Initial You will only keep your in-person appointment if you are symptom free. If symptoms are present as outlined in the Revised Supplemental Informed Consent, the appointment will be canceled and moved to telepsychology if possible.

Initial You will wait in your car until your session time and not the waiting room. You will text Dr. Dungan at (317-384-7196) when you have arrived and Dr. Dungan will inform you when it is time to come to session.

Initial Parents with minors may not wait in the waiting room until the session is complete. They must wait in their car or outside of the building. They may text any concerns or come in at the end of session for any updates.

Initial Hand sanitizer will be available in Dr. Dungan's office.

Initial You will adhere to safe distancing precautions Dr. Dungan has outlined in the Revised Supplemental Informed Consent and posted on her office door. There will be no physical contact (i.e., hugs, handshakes) and you will sit where asked during session.

Initial You will notify Dr. Dungan of any potential exposure risks including jobs, or activities.

Payment Agreement

Dear Client/Responsible Party on Behalf of Client:

By signing and dating this form, you agree to be personally responsible for all charges incurred through the services provided by Dr. Dungan. This includes cost of intake, therapy sessions, testing sessions, no-show appointments, and late canceled appointments.

Payment for services is due at the time of service. For self-pay patients, the agreed upon amount is due at the time of service. For insurance-based patients, an estimated cost of service will be due at the time of service. These estimated costs will be explained in detail during the intake session. Additional fees will be incurred if there are no-show appointments or late canceled appointments. The fees for these missed appointments will be added to the amount due for both self-pay patients and insurance-based patients during the next session.

If you use insurance benefits, Dr. Dungan will attempt to verify your benefit coverage for her services to the best of her ability by contacting your insurance company. She needs to inform you; however, that benefit coverage does not guarantee payment by your insurance company. If coverage is denied by your insurance company, you will be personally responsible for all charges incurred by signing and dating this form.

If services are terminated and there is a remaining balance due, Dr. Dungan will attempt to contact you to collect payment. If she is unable to reach you after a reasonable period, she will charge the credit card on file to settle the balance.

By signing below, you agree to all terms and conditions outlined in this document. You acknowledge that you are the Parent/Legal Guardian of the patient, and understand that your signature is legally binding.

Child's name

Date of Birth

Parent/Guardian's name

Today's Date

Signature of Parent/Legal Guardian