Date completed ____/____/____

CHILD/ADOLESCENT REGISTRATION FORM

E3 Solutions of North Carolina, 901 Paverstone Drive Suite 5, Raleigh, NC 27615
Phone: (919) 906-2891 · Web Address: www.e3solutionsnc.com

Child and Parent Information

Client's Full Name (Last, first, middle):
Client's home address:
City: **State:** **Zip:**
Client's birth date: **Client's Sex (circle one):** **M** **F**
If client is employed, circle one: **Full time** **Part time**
If client is a student, circle one: **Full time** **Part time**
Name(s) of client's parents/custodian/legal guardian:
Parent's home phone #: **Work #:** **Cell #:**
Parent's Email Address: **Parent's SS#**
Please circle where confidential messages may be left for Parent: Home Work Email
If parents are separated/divorced, who has legal custody of this child?
Name and address of person to whom CSI should send bills (*if different from above*):

Insured's (policy holder) Primary Policy Information

Insured's name (last, first, middle**):** **Insured's DOB: _____** **SS# of Insured:**
Relationship to insured: **Self** **Spouse** **Child** **Other(**specify**)**
Primary Insurance Co. Name:
Policy /Member ID #: **Group #:**
Deductible Amount: **Co-payment Amount:** ***Has deductible been met?*** **Y** **N** **Eff. Date of Policy:**
Does policy require that mental health benefits be pre-authorized? YES NO **If yes, please provide authorization number:**
If Employee Assistance Plan (EAP), please enter name and authorization #:
Is policyholder insured under employer's health plan (circle one)? YES NO
Employer name:

Note: Please provide insurance card for photocopy. Thank you!

I request and authorize E3 Solutions of NC to provide evaluation and/or treatment for my child. I hereby authorize the release to my insurance company of any medical information necessary to process claims for services provided by E3 Solutions of NC. I authorize payment of medical benefits to E3 Solutions of NC. I agree that I am responsible for any balance not reimbursed by my insurance company. I understand a collection and/or finance charge may be applied to any balance over 90 days past due.

_____ _____

Signature of Patient or Responsible Party Date