Annapolis Valley Psychological Services Inc.

REGISTRATION FOR INDIVIDUAL PSYCHOLOGICAL SERVICES (Children)

Today's Date: _____

Preferred Pronoun: _____

Full Name: _____

Mailing Address: _____

_____

Phone Number: _____ Email: _____

Date of Birth: _____ Age: _____

Grade: _____ School: _____

Parent/Guardian Name(s): _____

_____

Parent/Guardian Occupation: _____

_____

Siblings (Names & Ages) _____

_____

_____

Physician Name: _____

Address: _____

Phone Number: _____

Prior Psychological or Psychiatric Services (Clinicians Names & Dates):

_____

_____

Present Psychological Services will be paid for by (please check one):

_____ Parent/Guardian

_____ Other (please specify): _____

Coverage Specifics: Limit Amount $_____ Percent Covered _____ Renewal Date _____

Direct Billable or Reimbursed? _____ Dr. Note Required? _____

Referral Source (please check all that apply):

_____ Family/Friend/Acquaintance

_____ Family Physician

_____ Internet Advertisement

_____ Other (please specify): _____

_____ Association of Psychologists of NS (APNS Website)

_____ AVPS Inc. Psychology Website

_____ Internet Search (google, yahoo, etc.)

Parent/Guardian Signature _____ Date _____