Erin C. Millhem, Psy.D.
Licensed Clinical Psychologist
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CHILD REGISTRATION FORM	
CHILD'S NAME:	DATE OF BIRTH:
PARENT/GUARDIAN NAME:	PARENT/GUARDIAN NAME:
ADDRESS:	ADDRESS:
EMAIL:	EMAIL:
CELL:	CELL
ALTERNATIVE PHONE:	ALTERNATIVE PHONE:
EMERGENCY CONTACT NAME:	EMERGENCY CONTACT PHONE:
If an emergency situation arises that requires medical attention should involve the named above child, I the legal guardian of said child hereby authorize Erin Milhem to secure emergency medical treatment by dialing 911. This authorization shall remain in effect for the time my child is receiving services unless cancelled in writing and filed with Erin Milhem.	
PARENT/GUARDIAN SIGNATURE:	DATE:

INSURANCE/PAYMENT INFORMATION	
INSURANCE PROVIDER:	CO-PAY:
POLICY HOLDER NAME:	POLICY HOLDER DOB:
POLICY NUMBER:	CREDIT CARD #:
GROUP NUMBER:	EXP: CVC: ZIP:
I authorize Erin Milhem, Psy.D to bill my insurance for services rendered. I have read the service agreement and understand billing procedures and policies.	
SIGNATURE:	DATE: