Allen E. Rush, MA, LPC

4R Farm Equine-Assisted Counseling

Registration Form

Client Information

Child's Name: _____ Age:_____ Gender: M_____ F_____

Nickname: _____ Date of Birth: _____

Physical Street Address: _____ City: _____ Zip: _____

Mailing Address (if different): _____ City: _____ Zip:_____

Parent/Guardian contact: Home: _____ Cell: _____ Work:_____

Email: _____

May we leave a message on your voicemail?_____ May we text and email you?_____

Child's School_____ Grade: _____ Teacher: _____

Emergency Contact (s): _____ Phone: _____

How did you hear about Mr. Rush? _____ May we thank this person?_____

Insurance Information

Insurance Company: _____ ID#:_____ Group #:_____

Insured's Name: _____DOB: _____ Male ____ Female ____

Insured's Employer: _____ Insured's Employer Work #:_____

Client's relationship to the insured: _____

Does the patient have any secondary insurance?_____ If yes, complete the following:

Insurance Company: _____ ID#: _____ Group #:_____

Insured's Employer: _____ Insured's Employer Work #:_____

Personal History

What problem(s) is your child experiencing that brings you to see Mr. Rush? _____

_____

_____

_____

_____

_____

How long has this been going on? _____

Has the child had previous evaluations or treatment? Yes _____ No _____ If Yes, please describe: _____

_____

Medical

Name of child's Pediatrician/Physician: _____

Address: _____ Phone: _____

List any current health conditions:

_____

What medications (and dosages) are currently being taken (and for what purpose)?_____

_____

_____

_____

Family

Biological Parents:

Mother: _____ Age_____ Father: _____ Age_____

Adoptive Parents (if applicable):

Mother: _____ Age _____ Father: _____ Age _____

Stepparents (if applicable):

Stepmother: _____ Stepfather: _____

Who has legal guardianship of your child? _____

Who does the child currently live with? _____

Consent to Services

My signature attests to the following: (1) I have read the Agreement for Counseling Services, understand it, and consent to counseling services for myself and/or my family; (2) I authorize Allen E. Rush, MA, LPC to release any pertinent information acquired during the course of my evaluation and treatment to my insurance company; (3) I am ultimately responsible for payment of charges for services rendered by the provider; and (4) I understand that Allen E. Rush, MA, LPC is a solo practitioner in independent practice and is not part of a group practice.

Signed: _____Date: _____
(Parent/Guardian)