

Mark R. Dell, Psy.D, L.L.C.
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(609) 439-6526

TEENAGE BOYS: PARENT/GUARDIAN & CLIENT REGISTRATION AND CONSENT

Date of Registration: _____

CLIENT INFORMATION (teenage client)

Client Name: _____ Date of Birth: _____ Age: _____
Client Phone (optional): _____ School / Grade: _____

PARENT / GUARDIAN INFORMATION

Name: _____ Relationship to client: _____

Phone: _____ Email: _____

Address: _____

Second parent / guardian: _____ Relationship: _____

Phone: _____ Email: _____

Legal custody:

- ☐ Parents share legal custody (both are asked to sign this form)
☐ One parent has sole legal custody (please bring a copy of the custody order)
☐ Other: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referred by: _____ Primary Care Physician: _____

INSURANCE STATUS

- ☐ Self-Pay (this practice does not bill insurance) ☐ Client will seek out-of-network reimbursement

CONSENT & ACKNOWLEDGMENTS

Parent/guardian: please initial each item below.

- _____ I consent to psychological treatment of my son by Dr. Mark R. Dell, Psy.D., and I have the legal authority to give this consent.
- _____ I have received and reviewed the Notice of Privacy Practices (HIPAA).
- _____ I understand that my son is the client. This is individual therapy for him. It is not a custody, school, or court evaluation, and in the role of my son's therapist Dr. Dell does not make custody or parenting-time recommendations.
- _____ I understand that New Jersey law may give a client aged 16 or 17 the right to consent to outpatient counseling and to control disclosure of what he says in sessions. For that reason, Dr. Dell and my son will agree at the start on what is shared with parents. As a general practice, I will receive: attendance and scheduling, billing, general progress and treatment goals, and notice of any serious safety concern. I will not receive the content of sessions unless my son agrees, or the law requires or permits disclosure.
- _____ I understand the limits of confidentiality, including mandatory disclosure in cases of imminent danger to self or others, suspected abuse or neglect of a minor, elder, or dependent adult, or as required by court order.
- _____ I understand this practice does not accept insurance. The fee is: Individual Psychotherapy (CPT 90834, 50 min): \$240.00. As the signing parent/guardian, I am responsible for the fee.
- _____ I understand payment is due in full at the time of service.
- _____ I understand the cancellation policy: appointments require 24-hour notice. Cancellations with less than 24-hour notice, or missed appointments (no-shows), will be charged the full session fee of \$240.00.

- _____ I may request a superbill for possible out-of-network insurance reimbursement. I understand reimbursement is not guaranteed and is determined solely by my insurance carrier.
- _____ I understand my son's treatment records will be retained in accordance with New Jersey law (a minimum of seven years from the date of last entry, or until age 25 for a minor patient, whichever is longer).
- _____ I understand that if any sessions are held by video, I and my son will complete the separate Telehealth Informed Consent.
- _____ I understand this practice does not provide emergency or crisis care. In an emergency, I will call 911 or 988 (Suicide & Crisis Lifeline), or go to the nearest emergency department.

CLIENT AGREEMENT (teenage client)

I have read this form, or it has been read to me. I agree to attend sessions. I understand what my parent(s) or guardian(s) will and will not be told, as described above, and I know I can ask Dr. Dell about it at any time.

Client Signature: _____ Date: _____

Printed Name: _____

Parent / Guardian Signature: _____ Date: _____

Printed Name: _____

Second Parent / Guardian Signature (if legal custody is shared): _____ Date: _____

Printed Name: _____

Provider Signature: Mark R. Dell, Psy.D. Date: _____

NJ License #: 35SI00480700 NPI #: 1053635409