

The Center for Emotional Health
Pamela M. Goldberg, RN, M.S., LMFT
6284 S. Rainbow Blvd., Suite 110
Las Vegas, NV 89118
702-257-0140 (203) Fax: 702-257-0139

Teen Talk Registration Form, 2009

Date: _____
Teen's name: _____
Lives with: _____ How long: _____
Age _____ Date of Birth: _____
Teen's cell phone: _____ Home phone: _____
Email address: _____
Grade _____ School: _____

MOTHER:

Name _____
Address _____ Zip code _____
Phone (home) _____ (work) _____ (cell) _____
E-mail address _____

FATHER:

Name _____
Address _____ Zip code _____
Phone (home) _____ (work) _____ (cell) _____
E-mail address _____

OR OTHER LEGAL GUARDIAN

GUARDIAN:

Name _____
Address _____ Zip code _____
Phone (home) _____ (work) _____ (cell) _____
E-mail address _____

EMERGENCY CONTACT INCLUDING ONE GUARDIAN AND ONE OTHER

1. Name _____ Phone _____ Cell _____
2. Name _____ Phone _____ Cell _____

Circle the issues you would like to address during this group series below:

- Poor impulse control mood swings difficulty expressing feelings
- Low self-esteem involvement with substances or alcohol
- Need to be center of attention Wrong choices unhealthy relationships
- Involved in risky behavior always getting punished
- Bottle up feelings dramatic overly sensitive
- Physical ailments difficulty trusting friends no avenue for creativity
- Problems with school not getting along with family get stuck
- Don't feel safe unable to cope with feelings no confidence
- Feel misunderstood negative peer group thinking negative thoughts

Number the above issues according to your priority.

List Medical Problems Below:

Food or drug allergies: _____

List below name of current medication, dosage and reason for taking:

(Drug) _____ (Dosage) _____ reason _____

(Drug) _____ (Dosage) _____ reason _____

(Drug) _____ (Dosage) _____ reason _____

Emergency Medication that should be with you at all times:

Reason _____ Drug _____

CONSENT TO ATTEND GROUP

I hereby give my consent to attend a teenage girls counseling group called **Teen Talk**. This group runs for 8 consecutive weeks. Sessions are 1 and ½ hours in length. I understand that I should arrive at least 5 minutes prior to start time. I have arranged transportation to and from group with a responsible person. I will not smoke within 50 feet of the building, partake in illegal substances nor bring anything illegal or inappropriate into the group.

I am aware that **Teen Talk** is a counseling group and that I am not allowed to discuss other group members or specific issues when outside of the group. I understand that the group leader/s is a mandated reporter. This means that if the leader discovers that a minor or elderly person has been abused (this could include emotional, physical or sexual abuse), or is in danger of seriously harming herself or another person, the leader has an ethical and legal obligation to report to the appropriate authority.

If I am a minor, my parent/s may call and leave important or unusual incidents with Pamela on her cell phone or via email. Please sign below attesting to the fact that you have read this information and give your consent.

Teen Signature

Parent or Guardian (if minor)

Date: _____

PAYMENT POLICY: The current price of the 12 hour Teen Talk program is \$650.00 which must be paid in advance by check, cash or credit card. If other arrangements have been made, write below the agreement that you made with Pamela in the space provided.: _____

Initials: _____

HEALTH INSURANCE: Some insurance providers may help pay for these sessions so check your policy. *This office requires payment in advance.* We will however, fill out a super bill that provides you with the information needed to seek payment directly from your insurance provider. If you do seek reimbursement from your insurance, the therapist is required to give a diagnosis code. If a previous diagnosis has been given by another health care professional, please inform this office when the super bill is filled out. Once this super bill is given to you, you are then responsible for proper filing, shredding, mailing or faxing in an appropriate manner. This office will not keep paper or electronic copies of any insurance statements. Please sign below that you have read and understand this payment policy.

Teen Signature

Date: _____

Parent or Guardian (if minor)