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**SEMEL  
INSTITUTE**  
U C L A



**Clinic Coordinator  
Contact Information:**

310-825-0142 ph  
310-206-4446 fax  
[www.semel.ucla.edu/socialskills](http://www.semel.ucla.edu/socialskills)  
[parenting@mednet.ucla.edu](mailto:parenting@mednet.ucla.edu)

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## UCLA Parent Training Program

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Enclosed you will find a number of forms that will help us to determine the appropriateness of our program for you and your child. Filling out these forms is equivalent to a one hour interview at no cost to you. It is important that you complete each questionnaire before you return them.

**Please return your packet promptly as enrollment is limited to each group!**

- Child Background Form**
- SNAP-IV Rating Scale**
- Parent-Child Conflict Questionnaire**
- WING**
- Insurance Information Form**

### **When complete, you may return the packet to us:**

1. Mail to: UCLA Parent Training Program, 760 Westwood Plaza, Rm 27-384 Los Angeles, CA 90095, Mail Code 175919
2. Fax to 310-206-4446 (please email [parenting@mednet.ucla.edu](mailto:parenting@mednet.ucla.edu) to confirm we received the fax)

Once we receive the packet, we will contact you to schedule a phone screen and one-hour intake appointment for enrollment in an upcoming group.

Thank you for your time. We look forward to meeting you. If you have any questions, please call our Clinic Coordinator at **310-825-0142**.

Patient Identification

## Child and Adolescent Psychiatry Clinic Background Information Sheet

Child's Full Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Child's Age: \_\_\_\_\_ Child's Gender: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ Place of Birth: \_\_\_\_\_

Child's Race/Ethnicity:  White  Black  Hispanic/Latino  Asian/Pacific Islander  Native American  
 Other: \_\_\_\_\_

Language Spoken at Home:  English  Other: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_  
\_\_\_\_\_

**\*Please indicate the best phone number to contact**

Parent/Guardian 1:

Name: \_\_\_\_\_ Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Parent/Guardian 2:

Name: \_\_\_\_\_ Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Other (if applicable, i.e. biological parent, step parent):**

Name: \_\_\_\_\_ Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

**The child lives with:**

- Both Biological/Adoptive Parents
- Single Parent: Please note:  Mother or  Father
- Mother and step-father
- Father and step-mother
- Equal time with separated/divorced parents
- Other: \_\_\_\_\_

**Current marital status of biological parents:**

- Married  How long: \_\_\_\_\_
- Separated  How long: \_\_\_\_\_
- Divorced  How long: \_\_\_\_\_
- Other  Describe: \_\_\_\_\_

If parents separated/divorced, who has legal custody in terms of physical/mental healthcare? \_\_\_\_\_

Is child legally adopted?  No  Yes If yes, age at adoption: \_\_\_\_\_

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**Parents' education (highest level completed):**

**Parent 1**

**Parent 2**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. Some school but less than completion of high school         | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Up to high school diploma or equivalent (GED)               | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Technical/trade school or some college                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. College graduate or equivalent (B.A., B.S.)                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Post graduate/Professional degree (M.A., Ph.D., M.D., J.D.) | <input type="checkbox"/> | <input type="checkbox"/> |

**Child's siblings (list names and ages)**

Full brothers: \_\_\_\_\_

Full sisters: \_\_\_\_\_

Half/step siblings: \_\_\_\_\_

**Child's Current School:**     Public     Private     Homeschooled     Not in School     Other: \_\_\_\_\_

Name of School: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

*\*If completing during summer break, please indicate grade level for **next** academic year*

How many years at current school: \_\_\_\_\_

**School History**

**Has your child:**

Currently

In the Past

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. Had an Individualized Education Plan (IEP)?                | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Had a 504 or other accommodations?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Attended resource, remedial, or special education classes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever repeated or failed a grade?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Had difficulty making/keeping friends?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Had behavioral problems in school?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Been suspended or expelled from school?                    | <input type="checkbox"/> | <input type="checkbox"/> |

**What is your child's current school performance:**

Failing     Below Average     Average     Above Average

Patient Identification

**Developmental History**

**When did your child:**

Say his/her first words: \_\_\_\_\_  
 Put two or more words together: \_\_\_\_\_  
 Take his/her first steps: \_\_\_\_\_  
 First become toilet trained: \_\_\_\_\_

**Child Mental Health History**

*Please fill in the relevant diagnoses.*

<b>Child Mental Health History</b>	<b>Age</b>	<b>Who Diagnosed?</b>	<b>Treatment Received?</b>
Obsessive Compulsive Disorder	_____	_____	_____
Tourette's/Other Tic Disorder	_____	_____	_____
Anxiety Disorder	_____	_____	_____
Attention Deficit Hyperactivity Disorder	_____	_____	_____
Depression	_____	_____	_____
Bipolar Disorder	_____	_____	_____
Eating Disorder	_____	_____	_____
Autism Spectrum Disorder	_____	_____	_____
Mental Retardation	_____	_____	_____
Posttraumatic Stress Disorder	_____	_____	_____
Psychotic Disorder	_____	_____	_____
Substance Abuse	_____	_____	_____
Learning Disorder	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____
Other: _____	_____	_____	_____

Has your child ever had thoughts of wanting to hurt himself/herself?  Yes  No

**Medical History** (type and date):

Allergies: \_\_\_\_\_

Significant illnesses: \_\_\_\_\_

Significant injuries: \_\_\_\_\_

Significant operations/medical procedures/hospitalizations: \_\_\_\_\_

Patient Identification
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**Child Medication History**

Medication	Start Date	End Date <small>(if applicable)</small>	Current/Final Dose	How Effective? Any Side Effects?

**Child History of Psychiatric Hospitalizations:**  No  Yes

If yes, please describe:

Hospital	Admission Date	Discharge Date

**Has your child ever had legal problems?**  No  Yes, please describe: \_\_\_\_\_

**Family History of psychiatric / emotional problems:**

- |   |  |
|---|--|
| <input type="checkbox"/> Anxiety Disorder<br><input type="checkbox"/> Bipolar Disorder<br><input type="checkbox"/> Autism Spectrum Disorder<br><input type="checkbox"/> Posttraumatic Stress<br><input type="checkbox"/> Learning Disorder<br><input type="checkbox"/> Attention Deficit Hyperactivity Disorder<br><input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mental Retardation<br><input type="checkbox"/> Psychotic Disorder<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Obsessive Compulsive Disorder<br><input type="checkbox"/> Tourette/Other Tic Disorder<br><input type="checkbox"/> Substance Abuse<br><input type="checkbox"/> Other: _____ |
|---|--|

Patient Identification

**Child's Pediatrician/Primary Care Physician**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

**Does your child have any other doctors or clinicians?**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Discipline:  Psychiatrist  Psychologist  Neurologist  Other: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Discipline:  Psychiatrist  Psychologist  Neurologist  Other: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Patient, Parent or Legal Guardian)

\_\_\_\_\_  
(Date and Time signed)

\_\_\_\_\_  
(Printed Name)

Child Name: \_\_\_\_\_

Date: \_\_\_\_\_

Completed By:  Mother  Father  Other: \_\_\_\_\_

**Please rate your child’s behavior below. Please note: If your child is currently taking medication please answer the questions below according to your child’s behavior when they are off the medication.**

**SNAP-IV RATING SCALE**  
**James M. Swanson, Ph.D**

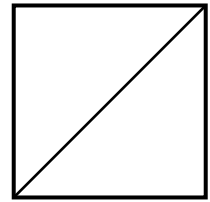
Check the column which best describes this child:

	Not at All	Just a Little	Pretty Much	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Often has difficulty sustaining attention in tasks or play activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Often does not seem to listen when spoken to directly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Often has difficulty organizing tasks and activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Often avoids, dislikes, or has difficulties engaging in tasks that require sustained mental effort (such as schoolwork or homework)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Often loses things necessary for tasks or activities ( e.g., school assignments, pencils, books, tools, or toys)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is often easily distracted by extraneous stimuli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Often forgetful in daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Often fidgets with hands or feet, squirms in seat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Often leaves seat in classroom or in other situations in which remaining seated is expected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Often runs about or climbs excessively in situations where it is inappropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Often has difficulty playing or engaging in leisure activities quietly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Is always “on the go” or acts if “driven by a motor”	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Often talks excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Often blurts out answers to questions before the questions have been completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Often has difficulty awaiting turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Often interrupts or intrudes on others (e.g., butts into other’s conversations or games)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Often argues with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Often actively defies or refuses adult requests or rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Often deliberately does things that annoy other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Often blames others for his or her mistakes or misbehavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Often touchy or easily annoyed by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is often angry and resentful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is often spiteful or vindictive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Office Use Only:</b>			
Total item ratings =	_____/9	_____/9	_____/8
Avg rating per item =	_____	_____	_____

Child Name: \_\_\_\_\_ Date: \_\_\_\_\_

Completed By:  Mother  Father  Other: \_\_\_\_\_



## PARENT-CHILD CONFLICT QUESTIONNAIRE

In order to know how best to help you we need to know how you feel you should relate to your children. This may not be what you are actually doing with your children now. You may find some of these questions difficult. Don't be discouraged; just circle the letter next to the one answer that you think is best.

1. **Suppose Tommy has not been doing his homework, and his mother would like him to. The first thing she might do is:**
  - (a) Say, "would you please do your homework now?"
  - (b) Wait until he starts, then help him with it.
  - (c) Tell him, "If you don't do your homework, then you can't go out and play later."
  - (d) Tell him, "It's time to do your homework now", in a neutral tone of voice.
  
2. **Mrs. Johnson has told her son Tommy, 8 years old, to stay in the house. Tommy yells at her, heads for the door and comes back while complaining about how "mean" his mother is. What should Mrs. Johnson do?**
  - (a) Tell Tommy she loves him.
  - (b) Talk over the problem.
  - (c) Tell Tommy warmly that she likes it when he does what she tells him.
  - (d) Tell Tommy he had no right to yell at her. He should respect his mother more.
  
3. **Suppose that Tammy has difficulty getting to school on time in the morning. How could her father help her best?**
  - (a) Frequently remind her to hurry up.
  - (b) Help her with all of her morning tasks each day.
  - (c) Let her know exactly what her morning tasks are, and note which ones she is doing well.
  - (d) When she is late, tell her "If you'd gotten out of the house sooner, you wouldn't be late for school!"
  
4. **Mrs. Johnson want Tommy, age 10, to clean his room each evening. She wants to put up a sign to remind him. How can she best write the sign to the job done?**
  - (a) "Remember to clean your room!"
  - (b) "Pick up all toys by 8 p.m."
  - (c) "Dirty room means no T.V.!"
  - (d) "No dirty rooms!"
  
- 5a. **Mrs. Johnson has just seen Frank, age 7, hitting his sister, age 4. This is a frequent problem with Frank and Mrs. Johnson would like to talk to him about it. She should:**
  - (a) Pick a time when they are both calm.
  - (b) Start to discuss the problem when they are still fighting, to distract their attention.
  - (c) Wait until Frank's favorite T.V. program is on, turn off the T.V. and talk to Frank.
  - (d) Tell the children that if they calm down, they can discuss the problem with you while eating ice cream.



- 5b. **In the above example, when discussing the example of fighting, Mrs. Johnson should:**
- (a) Tell Frank the reasons why he shouldn't fight with his sister.
  - (b) Simply state the problem and ask Frank to help with the solution.
  - (c) Simply state the problem and ask Frank why he does it.
  - (d) Both (a) and (c)
6. **Tommy is throwing his ball so hard that he may accidentally hurt a child standing nearby. What should his mother do?**
- (a) Walk up next to Tommy and lean towards him.
  - (b) Tell him in a firm tone of voice "I want you to throw that ball away from the other children, please".
  - (c) If he starts to face away from the other children say, "That's right! Throw it safely", in a warm tone of voice.
  - (d) All of the above.
  - (e) Both (a) and (b).
7. **Suppose you want to have a talk with your 4 year old child about something she does that frequently bothers you. You should:**
- (a) Explain to her why what she's doing is wrong, so she'll understand better what the problem is.
  - (b) Describe the problem to her and how it makes you feel, calmly and briefly.
  - (c) Praise her if she is listening or helping with the solution.
  - (d) Answers (b) and (c) only.
8. **Mr. Johnson has repeatedly asked Tony, age 10, to feed his pet after school. He does this sometimes. What should Mr. Johnson say after Tony does this?**
- (a) "I really like it when you listen to me!"
  - (b) "That's great! Why couldn't you do that before?"
  - (c) "I really like that. Remember to do it tomorrow!"
  - (d) "I'm really glad you didn't forget this time!"
9. **Tommy and his sister are teasing each other loudly in the back seat of the car, so that Mrs. Johnson is having trouble driving safely. Which of the following would be the most effective warning?**
- (a) After pulling over to the side of the road, she says, "If you are quiet, then we can continue riding".
  - (b) "Wait until we get home!"
  - (c) "If you don't stop that, then no T.V. when we get home".
  - (d) After pulling over to the side of the road, she explains how dangerous it is to misbehave in the car.

Child Name: \_\_\_\_\_

Date: \_\_\_\_\_



Completed By:  Mother  Father  Other: \_\_\_\_\_

## WING

This child stands out as different from other children of his/her age in the following way:

	NO	SOMEWHAT	YES
1. Is old-fashioned or precocious.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is regarded as an "eccentric professor" by the other children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Lives somewhat in a world of his/ her own with restricted idiosyncratic intellectual interests.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Accumulates facts on certain subjects (good rote memory) but does not really understand the meaning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has a literal understanding of ambiguous and metaphorical language.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has a deviant style of communication with a formal, fussy, old-fashioned or "robot like" language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Invents idiosyncratic words and expressions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a different voice or speech.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Expresses sounds involuntarily; clears throat, grunts, smacks, cries or screams.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is surprisingly good at some things and surprisingly poor at others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Uses language freely but fails to make adjustment to fit social contexts or the needs of different listeners.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Lacks empathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Makes naïve and embarrassing remarks.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Has a deviant style of gaze.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Wishes to be sociable but fails to make relationships with peers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Can be with other children but only on his/her terms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Lacks best friend.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Lacks common sense.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Is poor at games; no idea of cooperating in a team, scores "own goals"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Has clumsy, ill coordinated, ungainly, awkward movements or gestures.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Has involuntary face or body movements.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Has difficulties in completing simple daily activities because of compulsory repetition of certain actions or thoughts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Has special routine; insists on no change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Shows idiosyncratic attachment to objects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Is bullied by other children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Has markedly unusual facial expression.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Has markedly unusual posture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**UCLA Parenting & Children's Friendship Program  
INSURANCE INFORMATION FORM**

We cannot guarantee our services will be covered by any particular health insurance program. Therefore, it is your responsibility to confirm your own coverage and if necessary obtain pre-authorization for our services. If your insurance company does not cover our program, we offer a self-pay fee of \$559.20 for the initial intake appointment.

Please complete the form below. When we schedule your initial evaluation at UCLA, we will have our finance department verify your insurance coverage.

**HEALTH INSURANCE (our services usually fall under behavioral or mental health)**

Insurance Provider: \_\_\_\_\_  HMO  PPO  POS

Subscriber/ Guarantor Name: \_\_\_\_\_

DOB of subscriber: \_\_\_\_\_ Relationship of Subscriber to patient: \_\_\_\_\_

Policy/Member ID/ Certificate #: \_\_\_\_\_

Group # (if applicable): \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Employer's Phone #: \_\_\_\_\_

Phone # for customer service (mental/behavioral health): \_\_\_\_\_

Authorization # (if applicable\*): \_\_\_\_\_

\*Many managed care insurance providers require their customers to call the customer service number on their insurance card and get pre-authorization for services prior to an initial appointment. **Please obtain an authorization number to see Cynthia Whitham, L.C.S.W. for an - outpatient initial evaluation at UCLA (CPT code 90791).**

The CPT for outpatient group therapy is 90853. Our facility code is 95-4377221 – UCLA Practice Plan

**SELF-PAY**

Self-pay fees:

- \$559.20 for intake appointment
- Please call the office for current weekly self-pay fees.
- Guarantor name: \_\_\_\_\_ Relationship of guarantor to patient: \_\_\_\_\_
- DOB of guarantor: \_\_\_\_\_

\*All fees may be subject to change without notice.