

You can complete this form on your computer if you have Adobe Reader version 5.0 or above. You will be able to print the completed form on your printer. You will not be able to save it once it is filled out unless you are using Acrobat Standard or Acrobat Professional (not the free program, Adobe Reader)

Today's Date: _____

Couples Information Form

Information About Both of You . . .

Partner #1	Partner #2
Name: _____	Name: _____
Address: _____ _____	Address: _____ _____
Age: _____ Date of Birth: ___/___/___	Age: _____ Date of Birth: ___/___/___
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Is it OK to telephone you and/or leave messages at home? (circle one) Y N At work? Y N	Is it OK to telephone you and/or leave messages at home? (circle one) Y N At work? Y N
Occupation: _____	Occupation: _____
Employer: _____	Employer: _____
# of Children: _____ # Previous Marriages: _____	# of Children: _____ # Previous Marriages: _____
Current physician: _____	Current physician: _____
List any major medical problems: _____ _____	List any major medical problems: _____ _____
Medications: _____ _____	Medications: _____ _____

Billing and Insurance Information . . .

How do you prefer to cover your expenses? [] Cash [] Insurance [] Employee Assist. Program [] Other

Note: Some insurance companies do not cover marital or family therapy. If you plan to use insurance benefits for these services, please check with your company before your first appointment to see if this is a covered benefit.

If insurance, name of primary insurance carrier: _____
Note: If you have one, please present your insurance card so that we may make a copy for our records.

Name of Subscriber: _____ Birth Date of Subscriber: _____

Policy Number, SSN, or Health Record # _____ Group Number: _____

How You Were Referred To Our Office . . .

Who referred you to our office? _____

I like to write brief note of thanks to professionals referring to our office. May I do this in your case? YES NO

A Note About Confidentiality and Release of Records . . .

Your clinician's notes will contain personal information about both of you. On rare occasion, one partner may wish access to those notes, or to have such records sent to a third party. It is our policy to release records only when **both** partners have given appropriate written consent. Please inform your clinician if you have any questions about this policy, or if you would like to deal with such a situation differently if it ever were to arise.

Please Read and Sign the Following . . .

My partner and I are applying for mental health consultation and/or treatment. We have been provided information regarding office policies, including fees, policies regarding missed appointments and late cancellations, the right to refuse treatment, releasing of records, choosing the best treatment provider, information about my clinician, and protecting the privacy of my healthcare record.

Signature

Partner's Signature

Insurance Authorization and Benefit Assignment . . .

If you plan to use insurance benefits to help cover evaluation and treatment costs, you will need to allow us to communicate with your insurer. Your signature below will allow us to bill your insurance company and to collect payment from them directly. Please review the following and sign below. Ask us if have any questions.

My signature below allows:

- Northwest Psychological Resources (NWPR) and my clinician to release basic, confidential information about me, such as date and type of service, diagnosis, and other information required to process my claim;
- My insurance company to pay benefits directly to NWPR to be applied to my account;
- NWPR to bill my insurance company in the future without me having to sign for this each visit.

I understand that I am responsible for any charges not covered or reimbursed by my insurer. Also, I understand that this authorization is valid until withdrawn by me in writing, and that I may revoke this release at any time except to the extent that action has already been taken in reliance on my consent.

Signature of Insurance Subscriber

Date

Print name and Social Security Number of partner responsible for payment of fees

_____-_____-_____
SSN