Adult Information Form

V05-22 Office Use: ID verified: _____ Type:_____

Name: _____Today's Date: _____

Mailing Address:_____City, State, Zip _____, _____, _____

Home Phone: _____ Cell Phone:_____ Date of Birth: ____/____/_____

E-mail address: _____@_____ . _____

Would you like automated e-mail reminders sent to this address of upcoming appointments? ☐Yes ☐No ☐Does not apply

Providing your e-mail is optional. E-mail communication is convenient, but should not be considered confidential. Providing your e-mail address assumes you understand and accept the risks to your privacy. Please discuss with your clinician their policies about how and when to communicate in this manner.

Occupation: _____ Work Phone: _____ Employer: _____

Sex: _____ Age:_____ Relationship Status: _____ Partner's Name: _____ # of Children: ___

Who is your current physician?_____ City: _____

List any major medical problems: _____

Medications and dosages:_____ _____ _____ _____

Use bottom of next page back if needed, or provide a list of your own

Is it OK to call and leave messages at home? ☐ Yes ☐ No | On your cell? ☐ Yes ☐ No | At work? ☐ Yes ☐ No

Whom can we call in case of emergency? _____ Phone # (_____) _____-_____

Who is responsible for payment on your account?

☐ Self ☐ Other: _____

Social Security Number of the financially responsible person: _____--_____--_____

***Why we need your Social Security Number* (SSN)**: If you are not paying cash in full, your clinician becomes a business offering you credit and carrying outstanding balances on your behalf. This is true even if you are using insurance or if you do not expect to have any co-payments to make. Having your SSN (or that of the financially responsible party) allows correct identification of the person responsible for your account. Your SSN is kept secure. Not providing this number assumes you are planning to pay cash at time of each service.

Would you like to keep a secured credit card number on file to charge for co-pays and balances due? If YES, please fill out the attached form on Page 5. *Keeping a credit card on file is optional. This can be a convenient way to pay future balances, pay your co-pay at time of service, or avoid the need to come by the office or mail in a payment. It can also prevent interest from accruing on past-due accounts and avoid costly collection actions. Your clinician can share more about how credit cards are handled. Just ask.*

Billing and Insurance Information

How do you prefer to cover your expenses?

◎ Cash ◎ Insurance + Copay ◎ Employee Assistance ◎ DSHS/CPS ◎ Attorney ◎ Other_____

If you are using insurance, be sure to provide our staff with all insurance cards for photocopying. If you also have a secondary insurance, please also list this below and present the card for photocopying. <u>If your card(s) show the information below, you do not need to fill these out.</u> We will get the information off your card.

Name of **Primary** Insurance Carrier: _____

Name of Insurance Subscriber:_____ Subscriber's Birthdate:_____

Subscriber's Employer: _____ Policy Number:_____

Name of **Secondary** Insurance Carrier: _____

Name of Insurance Subscriber:_____ Subscriber's Birthdate:_____

Subscriber's Employer: _____ Policy Number:_____

If you do not know what your insurance covers, please call them to obtain this information if at all possible before your first appointment. A customer services representative should be able to explain your deductibles and expected co-pays.

If there is anyone other than yourself that you would like to have access to scheduling your appointments or access to your account at this office, please list them here. _____

If desired, use this space to provide any additional information you would like your clinician to know about your situation, preferences, and/or needs. This may include a medication lists continued from the first page.

There are ***FOUR*** areas where we need your signature. State regulations require sign-off in each area. These include 1) allowing your clinician to speak with your medical provider, 2) allowing us to bill your insurance for services, 3) your permission to have telehealth services using the telephone or by videoconference if these are options you would like to use, and 4) your acknowledgement of having received information about your clinician, office policies, and protecting the privacy of your healthcare record.

1. *I give my permission for my clinician to speak with my primary care physician under the following conditions*:

Check one box

☐ *I don't have a primary care physician, this issue doesn't apply, or I prefer my primary care provider not be contacted.*

☐ *My clinician can communicate any and all information about my visits, as needed*.

_____ _____

Signature Date

2. 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 allows: 1) your clinician to release basic, confidential information about you, such as date and type of service, diagnosis, and other information required to process your claim, 2) your insurance company to pay benefits directly to your clinician to be applied to your account, and 3) your clinician to bill your insurance company in the future without you having to sign for this each time.

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 my revoke this release at any time except to the extent that action has already been taken in reliance on my consent.

_____ _____

Signature Date

3. Consent for Audio and Telehealth Sessions

An audio session is used to describe a mental health session conducted via telephone or over the Internet. State law requires that I have your permission to engage in this service with you. If you desire the option of telehealth services, please maintain a quiet and confidential environment without distractions during our sessions so we can make the most of our time together and be sure that our conversation cannot be easily heard by others to protect your confidentiality. Your signature below indicates you give your permission to engage in Audio Sessions with me and that you give permission to bill your insurance company for audio sessions. If you have questions as to whether your insurance policy covers audio session, please contact your insurance company to verify your benefits prior to your appointment.

_____ _____

Signature Date

4. Included with this intake information is a document entitled **Office Policies, Informed Consent for Treatment, and Protecting the Privacy of Your Health Record**. Let us know if you did not get one. Please look over this information and important policies. Take this document home with you. Governmental regulations require that we verify you received this material. Please print and sign your name below. Your clinician will sign their name and keep this page in your file.

I certify that I have received a copy of "Office Policies, Informed Consent for Treatment, and Protecting the Privacy of Your Health Record."

_____

Printed Name of Patient or Legal Guardian

_____ _____

Signature of Patient or Guardian Date

_____ _____

Signature of Clinician Date

Credit Card Guarantee Form

I understand my credit card number will be kept securely and confidentially on file.

I authorize billing my credit card under one or both of the following conditions:

Initial one or both options

_____ I ask that some or all of my personal balance be charged to my credit card as an alternative to writing a check or paying cash at the time of service, or as an alternative to mailing or bringing in a payment.

_____ If I have an outstanding balance more than 60 days past due and I have not already agreed with my clinician upon a plan of payment, then I allow my credit card to automatically be charged for the balance due to clear my account to avoid collections.

Card Information

Type Of Card: _____ Visa _____MasterCard _____American Express _____ Other _____

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____/ _____ CCV Code (number on the back – 3 digits) _____

Name on Card _____

"I hereby authorized Northwest Psychological Resources to charge the balance of my account for any fees not paid at the time of service under the conditions described above. I also agree to inform NWPR and provide updated information if this card is terminated, expires or changes in any way"

_____
Patient

_____ _____
Signature of Cardholder Date

_____
Clinician's Name