Couples Information Form *v2.5.13 Office Use: ID verified:_____ Type:_____ Clinician:_____*

Personal Information

Partner #1	***Partner #2***
Name: _____	Name: _____
Address:_____	Address:_____
_____	_____
Age: _____ Date of Birth: _____/_____/_____	Age: _____ Date of Birth: _____/_____/_____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____
Preferred Method of Contact (circle): Home Work Cell	Preferred Method of Contact (circle): Home Work Cell
Is it OK to leave messages at this number? Yes No	Is it OK to leave messages at this number? Yes No
Occupation: _____	Occupation: _____
# Children: _____ # Previous Marriages: _____	# Children: _____ # Previous Marriages: _____
Current Physician: _____	Current Physician: _____
Medical Problems: _____	Medical Problems: _____
_____	_____
Medications: _____	Medications: _____
_____	_____
_____	_____

Billing and Insurance Information

How do you prefer to cover your expenses?

◎ Cash ◎ Insurance ◎ 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 on the next page and present the card for photocopying.

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.

Would you like to keep a secured credit card number on file to charge for co-pays and balances due? ◎ Yes ◎ No

Keeping a credit card on file is optional. It can be a convenient way to pay future balances, pay your co-pay at time of service, or if you prefer not having to come by the office or mail in a payment. It can also prevent interest from accruing on past-due accounts, as well as avoid costly collection actions. Your clinician can share more about how credit cards are handled. Just ask.

Although both of you are seeking services and may have shared financial accounts, one of you must assume financial responsibility for payment on your account.

Which partner will assume this? ◎ Partner #1 ◎ Partner #2

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. 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.*

If desired, use this space to provide any additional information you would like your clinician to know about your situation, preferences, and/or needs:

Since you are both being seen as a couple, your clinician's records of your visits will contain information about both of you. In the hopefully unlikely event your relationship ends during or after services, please let us know how you both prefer to handle confidentiality of your record of care in the future:

	Initials Partner 1	Initials Partner 2
◎ Release records upon the written request of either partner.	_____	_____
◎ Release records only with the written permission of BOTH partners.	_____	_____
◎ Other: _____	_____	_____

Please complete the next page

Places for You to Sign

There are three areas where we need your signature. These include allowing your clinician to speak with your medical doctor, and allowing us to bill your insurance for services. The attached page deals with 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 either of our primary care physician under the following conditions*:

Partner #1	***Partner #2***
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.*  _____ Date: _____/_____/_____	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.*  _____ 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 of Insurance Subscribing Partner Date

_____ _____

If different than above, signature of Financially Responsible Partner Date

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

_____ _____

Signature of Financially Responsible Partner Date

_____ _____

Signature of Clinician Date

Please give this form to your clinician when he or she comes to greet you.