Adult Information Form

v3.30.12 Office Use: ID verified:_____ Type:_____ Clinician:_____

Information about You

Name: _____Today's Date: _____

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

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

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

If you have Caller ID, would you like us to block our name when calling your home? ☐ Yes ☐ No ☐ Does not apply

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

E-mail address: _____@_____ . _____

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.

If not yourself, provide the name of person responsible for payment on your account: (The person signing this form)

☐ 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. 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.

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 below 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 completely 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.

Your clinician wants to ensure that he or she is providing the best care possible based on your particular culture and language preference. Please complete the following information: (check one)

☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

☐ White/Caucasian ☐ More than one race Are you Hispanic or Latino? ☐ Yes ☐ No

Do you prefer to communicate in a language other than English? ☐ Yes ☐ No - If yes, which?_____

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

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 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. 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

Thank you.

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