Adult Information Form

v11.3.20 Office Use: ID verified: _____ Type:_____ Clinician:_____

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 but useful for allowing you to access my secure Therapy Portal to exchange documents and notices. Other direct e-mails should not be considered confidential but allowed if you understand and accept the risks to your privacy. Please discuss with your clinician their policies about how and when to communicate in ways other than the NWPR Therapy Portal.

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 # (_____) _____-_____

Who is responsible for payment on your account?

☐ Self ☐ Other: _____

Social Security Number of the financially responsible person on your account: _____--_____--_____

***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.

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. ***If your card(s) show the information below, you do not need to fill these out.*** *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 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. See the final page of these forms for more information.

We are asked by governmental agencies to collect this information, and your clinician wants to ensure that s/he is providing the best care based on your cultural and language preference. Please 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. This may include a medication lists continued from the first page.

Please complete the next page

Places for You to Sign

There are ***three*** areas where we need your signature. These include 1) allowing your clinician to speak with your medical doctor, 2) allowing us to bill your insurance for services, and 3) 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 do not have a primary care physician, this doesn't apply, or I prefer my primary care provider not be contacted.*

☐ *My clinician can communicate 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 <u>not</u> 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.

Debit/Credit Card and HSA Guarantee Form

We encourage you to allow us to maintain a debit/credit or Health Savings Account card on file in our secure billing system. This will allow us to 1) conveniently collect co-payments without you having to come to the front window each visit, 2) to easily and quickly clear balances owed after insurance has paid without requiring you to come in or mail checks to our office, and 3) to avoid potential problems with overdue accounts. Any charges resulting in a credit balance will be promptly refunded.

I understand my credit card number will be kept confidential and securely on file at Northwest Psychological Resources. I authorize billing my credit card under the one or both of the following conditions:

Please initial one or both options:

_____ I specifically ask that my visit co-payment or some or all of my personal balance be charged to my card as an alternative to writing a check or paying cash at the time of service, or as an alternative to me mailing or bringing in 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 card to automatically be charged for the balance due to clear my account to avoid interest, late payment fees, or collection processes.

Card Information

Type	***Card Number***	***CCV Code***
□ Visa □ MasterCard □ Other _____	_____ - _____- _____-_____	____ ____ ____ 3 digit code on back
Name as it appears on card *(please print clearly)*		***Expiration Date*** _____ / _____ Month Year

I hereby authorize 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.

_____ _____

Signature of Patient or Financially Responsible Guardian Date

OFFICE USE ONLY		
Clinician Last Name	Client Name	
Client Mailing Address _____ _____ , _____ _____		Amount charged: [ ] Co-payment only [ ] Current client balance due [ ] Other:_____
Notes:		