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Sound Family Psychiatry

CLIENT INFORMATION

First Name: _____ Last Name: _____

Preferred Name: _____ Race:_____ DOB: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ May I send mail here Y N

Home Phone: _____ May I leave a message here Y N

Cell Phone: _____ May I leave a message here: Y N

E-mail: _____ May I send you e-mail here: Y N

Gender: _____ Sexual Orientation: _____ Pronouns used: _____ Relationship Status: _____

EMERGENCY CONTACT: As part of confidentiality and safety protocols, I need to have a designated emergency contact. This person will only be contacted if I have concerns about your safety or the safety of others and have been unable to contact you directly. This will not be used to discuss clinical information, treatment plan, or scheduling – all of which would require a signed and current Release of Information. By signing at the bottom of the page, I acknowledge and agree that this person can be contacted in case of emergency, as determined by Melissa Rubin, DNP, ARNP.

Emergency Contact Name: _____ Phone: _____

Relationship to client: _____

I certify that the above information is complete and truthful to the best of my knowledge and ability. I understand that my personal information is kept confidential, unless an exception is made in accordance with the Disclosure Statement which I have received.

_____ _____
Signature of Client or Legal Guardian Date Signed

_____ _____
Print full name Relationship to Client (if applicable)

INSURANCE INFORMATION

I currently am paneled with the following insurance companies: Regence, Premera, First Choice, and some Aetna and Kaiser plans. If you are insured through one of these insurance companies and you would like your visit(s) with me billed through them, please provide insurance information below. I strongly recommend that you verify with your insurance company that I am an in-network provider through Sound Family Psychiatry, as well as confirming your deductible and any co-insurance/co-payments you may have.

Primary Insurance Co: _____

Plan Name: _____

Insured's ID#: _____ Group #: _____

Name of Insured: _____ Date of Birth of Insured: _____

Employer of Insured: _____

Insured's Address (if different from client): _____

Insured's Phone Number: _____ Relationship to Insured: _____

Secondary Insurance: _____

I hereby authorize my insurance benefits to be paid directly to the provider. I realize that I am responsible to pay for any non-covered services, and that I will be liable for a monthly finance charge of 1.5% on balances over 90 days past due. I hereby authorize the release of pertinent medical information to the insurance company.

Patient/Guardian Signature: _____ Date: _____

Patient Name (Printed): _____