Couple & Family Institute of Tri-Cities
8121 W Quinault Ave STE F202, Kennewick, WA 99336
(509)579-0200 Office – (509)232-0216 Fax

Referred by: ◯ Physician:______________________ ◯ Friend:__________________ ◯ Psychology Today ◯ Internet/Other

Name:____ Date of Birth:___/____/_____
First Middle Last

Address:____
Street City State Zip

Please Check One: ◯ Male ◯ Female Social Security #_________-______-_________

Cell/Phone:____ May we leave a message on this number ◯ Yes ◯ No

Marital Status:______________________ E-Mail Address:____

If under 18: Mother's/Father's name:____

Emergency Contact:______________________________ Phone #:_________________________ Relationship:_____________

Essential information must be filled out in order to have services with us.
Credit or Debit Card # to keep on file:___________________________________ Expiration Date:______/_______ CVC:______

Name on above card:____ Zip Code Associated with Card______________
*Card uploaded to secure software and then this form is shredded. *Card will be charged within 48 business hours after visit.

Name of Referring Physician:____

Address:____ Phone #___________________________

Insurance:

Primary Insurance:________________________________ Policy #:_____________________________ Group:______________

Policy Holders Full Name:____ ◯ Male ◯ Female

Policy Holders Date of Birth: ______/_______/_______ Relationship to Client:_______________________________________

Social Security #:______-_____-______ Address:____

*Notice of Privacy Practice Patient Acknowledgement:

I have received and/or reviewed this Office's Notice of Privacy Practices. The notice provides details about uses and disclosures of my protected health information that may be needed by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at/or controlled by the practice. I understand that I may obtain this practice's current Notice of Privacy Practices upon request.

*Release of Information:

Your clinician is not allowed to release information to anyone but the patient. If you would like our office to be able to discuss anything with anyone besides yourself, please indicate this below:

- ◯ Only myself
- ◯ Other:____ What:____________________ Relationship:_______________

By signing below I acknowledge that I have read and understand the above information, Please feel free to ask any questions.

Signature:____Date:______/______/_______
(If you are younger than 18 years of age, forms must be signed by parent or guardian)

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Please read carefully, as this is a legally binding financial agreement. We will bill your primary insurance if an insurance card is provided as a courtesy to you. Services denied due to missing or incorrect information are client's responsibility. Please verify any pre-authorization requirements and policy limitations for mental health services. Claims over 90 days will be applied to the client's balance. If insurance information is not provided, services will become the responsibility of the client.

We do not bill secondary insurance.

Missed appointments/Late cancellations: All evaluations and treatment visits are by appointment only. An appointment is a commitment to work together at a designated time and place. **Clients who fail to attend a scheduled appointment, or cancel after 10 am two (2) business days prior to their scheduled appointment, will be charged a fee (current up to the full amount of the session) Regardless of the reason for the no show or late cancellation.**

Signature:_______________________________________ Date:______/_______/________