



# Adult Information Form

Office Use: ID verified: \_\_\_\_\_ Type: \_\_\_\_\_ Clinician: \_\_\_\_\_

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell 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.*

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship Status: \_\_\_\_\_ Partner's Name: \_\_\_\_\_

# of Children: \_\_\_\_ and ages \_\_\_\_\_

Who is your current physician? \_\_\_\_\_ City: \_\_\_\_\_

List any major medical problems: \_\_\_\_\_

Medications and dosages: \_\_\_\_\_

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 I call in case of emergency? \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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 I 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:

There are three areas where I 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:**

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 may 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 I 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