80 11 118th Avenue NE Kirkland, WA 98033 www.attachmentcenternw.com Fax: 425-576-8274 Pone: 425-889-8524

Office use only

DX________

Date: ______________________

Client's Name (last/first/middle) ______________________ Date of Birth ___/___/___

Address ______________________ Current Age ______

City ______ State ______ Zip ______

Phone #'s w/area codes ______________________

Client's Employer (or School) ______________________ Occupation (or Grade Level) ______

Primary Complaint (Reason for this visit) ______________________

If Client is an ADULT

Marital Status: ____ single ____ married ____ divorced ____ separated ____ widowed

Spouse's Name ______________________

Spouse's Employer ______________________

Driver's License# ______________________ SS# ______________________ Spouse's Work Phone ______________________

If Client is a Minor

MOTHER'S Name	FATHER'S Name
Driver's License #	Driver's License #
Phone (if different)	Phone (if different)
Mother's Address (if different)	Father's Address (if different)
Mother's Employer	Father's Employer
SS#	SS#
Work Phone w/ area code	Work Phone w/area code

Name of person we should contact in case of emergency ______________________ Phone #'s ______ ______

Primary Care Physician ______________________ Phone ______

Referred by ______________________ Phone ______

I will be paying today by cash______ check______

Person responsible for this bill (if different than above) ______________________

Billing Address (if different than above) ______________________

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Office and Fee Policy, Privacy Statement

Thank you for choosing us as your mental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Office and Fee Policy which we require that you read, initial as indicated and sign prior to any treatment.

All patients must also complete our Patient Information Form before seeing the therapist.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE – UNLESS PRE-ARRANGED WITH THERAPIST.
WE ACCEPT CASH, CHECKS, AND VISA/MASTERCARD.
WE DO NOT TAKE MEDICAL COUPONS.

Regarding Insurance
It is the client's responsibility to pay for the first visit, regardless of insurance, unless pre-arranged.

We can *help* with insurance claims as a courtesy but are not required to do so. Payment for charges is the sole responsibility of the client.

We may accept assignment of insurance benefits. However, based upon verification of insurance benefits, we require the client portion be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. When the client is a minor and is not accompanied by the financially responsible adult, we require payment be sent prior to or paid at the time of service.

We cannot bill your insurance unless you bring in complete insurance information and complete a claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance.

Regardless of whether your insurance complies with Washington State law for 30-day processing and makes regular monthly payments as claimed or there is a delay in claim processing, the client is responsible for the client portion of each visit.

Usual and Customary Rates: Our practice is committed to providing the best for our patients and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Your fee for services is $175.00 for the first hour, then $125.00 for each 50-minute sessions. Lengthy or repeated phone calls and report writing will be charged at the standard fee of $125.00 per hour, pro-rated to the actual time spent on these activities.

_____ *Initials* Payment is past due at 30 days. We charge a $5.00 cumulative rebilling fee assessed every month on any balance over 60 days old. In addition, Washington State usury laws allow us to assess 1% finance charges per month.

_____ *Initials* **Minor Patients:** The parents (guardians) are financially responsible for the minor under these obligations stated above. If there is an instance where the minor is not accompanied by the financially responsible adults, we require payment be sent prior to or paid at the time of service. The parents (guardians) of a minor are responsible for authorizing treatment for the minor.

_____ *Initials* We do not and cannot guarantee any level of success in dealing with a particular client. Fees are therefore paid as consideration for the specialized therapeutic process and not for particular results for any client.

_____ **Missed Appointments:** Unless canceled at least 24 hours in advance, our policy is to
initials charge for missed appointments at the full rate of a normal office visit. Please help us serve you better by keeping scheduled appointments. Exceptions may be made for unforeseen emergencies.

Emergencies: In case of emergency, all our office at 425-889-8524. If your therapist is unavailable, leave a message that there is an emergency and request that contact be made as soon as possible. If you need help sooner, call the Crisis Clinic (206-461-3222) or go to your nearest hospital emergency room or Harborview Medical Center in Seattle.

Clients' Rights: It is your right to choose the therapist you wish to use, including the decision whether or not to work with us. It is your right to question the methods used in our work together. It is important for our work that you raise any questions you have so that we can discuss them. It is your right to refuse treatment or to terminate treatment at any time.

Confidentiality: The therapist/patient relationship is a confidential one. No information can be released without your written permission. However, confidentiality will not be maintained if you indicate that you intend to harm yourself or others, or if you are unable to take care of your basic human needs. State law also requires that any information regarding possible or suspected child abuse must be reported immediately to the Washington State Department of Social and Health Services.

______ **Privacy Practices:** "Protected Health Information" (PHI) is information about you,
initials including demographic information, that can be reasonably used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of related health care services to you or the payment for that care. This enclosed Notice of Privacy Practices tells you about the ways in which we may collect, use and discloses your PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. Your rights concerning your PHI are also discussed in this notice.

Ethics and Professional Standards: As licensed social workers and members of the Washington State Chapter of the National Association of Social Workers, we are accountable for our work with you. If you have any questions or concerns about the course of treatment, please discuss them with us. Should you feel that we have been unethical or unprofessional, you may contact the Washington State Department of Professional Licensing in Olympia or the Washington State Chapter of the National Association of Social Workers in Seattle.

Thank you for understanding our Office and Fee Policy. Please let us know if you have any questions or concerns.

Tom A. Gill, L I.C.S.W.
Beverly Cuevas, L.I.C.S.W.
Rebecca Perbix Mallos, L.I.C.S.W.
Mark Coen, M.S.W.

My signature below indicates that I have read the Office and Fee Policy and have read and received a copy of the Notice of Privacy Practices.

______________________________	______________
Signature of Patient or Responsible Party	Date
______________________________	______________
Signature of Patient or Responsible Party	Date
______________________________	______________
Therapist	Date
______________________________	______________
Therapist	Date

ATTACHMENT CENTER NORTHWEST
8011 118TH AVE. N.E.
KIRKLAND, WA. 98033
Phone: 425-889-8524, ext. 7#
Fax: 425-576-8274

INSURANCE INFORMATION FORM

Client name:____

Insurance Company:____

Insurance Company Claims Address:____________________________________
____

Subscriber Name:____
Member ID#____
Group #_________________________Phone # of Insurance:______________________

IT IS IMPORTANT TO CALL THE INSURANCE COMPANY AND GET THE FOLLOWING INFORMATION DIRECTLY FROM THEM TO AVOID CONFUSION. ***This part of the form is to assist you in requesting information from your insurance company about your outpatient mental health benefits. You can obtain this information by calling the Customer Service Department of your insurance company. The phone number is usually on your insurance card.***

Date eligibility began:____
Deductible, if any: $____
How much of the deductible has been met?_________________________________
Does your insurance have mental health benefits?____________________________
Number of visits allowed in a 12 month period?______________________________
Will an Outpatient Treatment Report be required?____________________________
Does the insured's plan require a referral or prior authorization from the insurance company or a broker agency for outpatient mental health services?_____________
If so, name of source of referral or prior authorization_________________________
____
Phone_________________________Fax______________________________
Insurance will pay __________% of usual and customary rates for outpatient mental health.
Information provided by:____
name of customer services representative

I understand I am responsible for knowing my specific insurance plan benefits:
Signature:__________________________________date:______________

REGISTRATION FORM

(continued)

Date: ______________________

Child's Name: ____
(Last) (First) (Middle)

Date of Parent's Marriages(s), Separation(s) and Divorce(s):

____

____

____

Level of Education: ____
(Father)

____
(Mother)

Others living at home	Sex	Birth date	Age	School and grade

Chief complaint and problem

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