A BRIEF COUNSELING CENTER
DBA: Healthy Counseling Center

9507 N. DIVISION STREET
HOLLAND BUILDING SUITE A
SPOKANE WA 99218

Phone: (509) 466-6632 Fax: (509) 466-0117 Email: office@healthycounselingcenter.com

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Patient Registration Packet

Patient Information Form

Please print and complete all entries. Thank you!

Patient Information

Name __________________________________ Date of Birth ________________ Age _____ Date ____________

Address __________________________________ City _______________________ State _____ Zip _____________

Home Phone ______________________________________ Cell Phone ____

Email ____

Employer ____

Social Security Number _______-_____-________ Driver's License Number ____________________________________

Spouse's Information

Name __________________________________ Date of Birth ________________ Age _____ Date ____________

Address __________________________________ City _______________________ State _____ Zip _____________

Home Phone ______________________________________ Cell Phone ____

Email ____

Employer ____

Social Security Number _______-_____-________ Driver's License Number ____________________________________

Financially Responsible Person (if other than patient)

Name __________________________________ Date of Birth ________________ Age _____ Date ____________

Address __________________________________ City _______________________ State _____ Zip _____________

Home Phone ______________________________________ Cell Phone ____

Email ____

Employer ____

Social Security Number _______-_____-________ Driver's License Number ____________________________________

Whom may we thank for referring you to us?

Name ____ Phone _______________________________

Address ____________________________________ City _______________________ State _____ Zip ____________

Emergency Contact Information

Name ______________________ Date of Birth ______________ Age _____ Date ____________

Address ______________________ City ______________ State _____ Zip ____________

Home Phone ______________________ Cell Phone ______________________

Email ____

Primary Care Provider

Name ____

Address ______________________ City ______________ State _____ Zip ____________

Phone ______________________ Fax ______________________

Insurance Information **A photocopy of insurance cards can be substituted**

Primary Insurance Company: ____

Address: ____

Phone# ____

Name of Policy Holder ______________________ Date of Birth: ____________

Policy number ______________________ Group# ____________

Is your condition related to: ❑ Employment ❑ Auto Accident ❑ Other Accident?

Date of First Symptoms: ______________ Dates of Similar Condition: ______________

Dates Unable to Work: ______________ Dates Hospitalized for Condition: ______________

Thank you for choosing Healthy Counseling Center for your counseling needs! You are in a safe place of hope and healing for the prevention and recovery of relational problems. You can ask any questions you may have about your counseling. Please take a moment to familiarize yourself with the following information.

Healthy Counseling Center's Office Policy

Please initial on each line to acknowledge that you have read and understood the policy.

Sessions are by appointment only. The initial intake appointment cost is $225.00 for one hour. Sessions are 45 minutes @ $135.00, and 53 minutes @ $150.00, unless we have made a mutual arrangement to adjust these fees. These appointments scheduled for you are set aside expressly for you, so we require 24 hours advance notice for cancellations. Appointments cancelled in less then 24 hours will be charged an $85.00 fee due prior to your next appointment. __________

Telephone consultations are billed at the same rate as regular sessions and fees for any written reports, court testimony, or special testing you may require will be discussed between us prior to those services. These services must be prepaid in advance. Fees start at $180. __________

Copays and coinsurance are due at the time of service. ____________

Payments on any unpaid balances and annual deductibles are due in full before your next session or payment arrangements must be made and honored to continue to seek counseling. All future payments after that will need to be paid with cash, credit card, cashier's check, or money order. _________

It is customary in our practice and required by all insurance companies with which we are contracted that all copayments and coinsurance are due at the time services are rendered. If for any reason, your insurance company denies benefits to you, you are responsible for all charges. ___________

Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card or unable to pay your copay or coinsurance, your appointment will need to be rescheduled. __________

You will be asked to fill out new registration forms annually (every January) to update your information. __________

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience. __________

You have a right to obtain your medical records; however, our providers must review all medical records request, before they are released from our office. For patient ages 13 to 17, they must consent to having their medical records released. Our office requires all patients to complete and sign a release of information form. There is a charge for your medical records. These charges will be discussed at the time of request. ___________

The law authorizes parent(s) or guardian(s) of a minor (anyone under age 13) to give informed consent on most medical decisions involving a minor. Minors whose biological parents are not married or no longer married both need to complete client intake packets. Our office policy also requires we have a copy of the parenting plan currently in place, any restraining orders, or other court information our office deems necessary. There are a few exceptions to this policy. Each exception will be evaluated by the provider prior to scheduling any appointments. ____________

Confidentiality Guidelines

The State of Washington protects the communication between you and your counselor as privileged and therefore must be confidential. This means any information you share in session with us is private and we have the legal and ethical responsibility to keep it confidential. If your treatment includes communication between your spouse, pastor, attorney, etc., and our providers, then you must sign a **Permission to Release Information**. Best practices and many insurance companies require our providers to communicate with your primary care physician about your diagnosis and treatment. There are special circumstances where the law of confidentiality will no longer apply in your treatment.

1. If you report to any counselor or they discover that a child or vulnerable adult is being sexually or physically abused, or profoundly neglected, then they are required by law to report this.
2. If your counselor believes that you are dangerous to yourself or others, they are required to contact authorities to protect you or to warn persons who may be in danger.
3. If you cannot care for yourself adequately, your counselor is required to assist you in establishing care and protection.
4. If you decide to bring a civil suit against someone, you waive all rights of confidentiality, since the court may subpoena our records and request testimony by our counselors concerning the nature of your treatment.
5. If you commit an unlawful act and are charged and brought to a court of law, your records may be subpoenaed and your counselor may be required to testify concerning the nature of your treatment.

____

Signature of patient/guardian/parent Date

____

Patient signature (ages 13 to 17) Date

Patients ages 13 to 17

☐ I, ____, do give permission to Healthy Counseling Center to release verbal and written results of my mental health records to my parent(s) / guardian.

☐ I, ____, do **NOT** give my parent(s) / guardian permission to obtain my mental health records.

Patient signature (ages 13 to 17) ____ Date: _____________

Complaints

Should you have any complaints, please notify our Office Manager: Jennifer Daniel at: 509-466-6632 ext. 1004

A Brief Counseling Center

DBA: Healthy Counseling Center

The Holland Building ~ Suite A
9507 North Division Street
Spokane, WA 99218-1556

Authorization for Service

I hereby authorize Healthy Counseling Center to render services to
(your name):____.

I have been provided a copy of the required disclosure information and an opportunity to read and understand the Client Registration Packet. I have had an opportunity to ask any questions about my counseling treatment.

I hereby:

- ➢ Authorize the release of any information necessary for the processing of third party payments.
- ➢ Authorize the release of any information to my primary care physician or prescribing medical personnel.
- ➢ Assign all medical and or mental health benefits to be paid to Healthy Counseling Center.
- ➢ Acknowledge receipt of the Notice of Privacy Practices.

A photocopy of this agreement is to be considered as valid as an original. This agreement shall be governed and enforced by the laws of the State of Washington and venue will take place in the State of Washington, County of Spokane, and City of Spokane.

Insurance is not a guarantee of payment; I will pay any costs in full from services rendered or appointment times reserved and not kept (**unless canceled 24 hours in advance**).

Copays and coinsurance are due at the time of service. Payments on any unpaid balances are due in full before your next session or payment arrangements must be made and kept to continue to seek counseling. There will be a $35 NSF charged on all return check.

I understand my rights and responsibilities and those of Healthy Counseling Center as outlined in the packet and agree its terms may change and to the conditions established by it.

____

Signature of patient/guardian/parent Date

____

Patient signature (ages 13 to 17) Date

ASSIGNMENT OF BENEFITS: I request that payment of authorized insurance benefits on behalf of A Brief Counseling Center DBA: Healthy Counseling Center for any services furnished to me.

____

Signature

AUTHORIZATION TO RELEASE INFORMATION: I authorize any holder of protected health information about me to release to my insurance and its agents any information necessary to determine these benefits or the benefits payable for services. Signature of patient (age 13 to 17) and holder of insurance policy and/or parent or legal guardian must accompany this form.

____

Signature

____

Signature (ages 13 to 17)