Patient Intake Information

Name: _____ Gender†: _____ D.O.B: _____ / _____ / ____
(First) (Middle) (Last)

Marital Status†: _____ Student*: Y / N
† As registered with insurance carrier. * If yes, please circle one: Full-Time / Part-Time

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ - _____

Email: _____

Emergency Contact: _____ Phone: (_____) _____ - _____

Insurance Carrier: _____
ie. Premera, Regence, Aetna, etc.

Policy Holder: _____ Employer _____

DOB: _____ / _____ / _____ Relationship to Patient: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

PLEASE READ CAREFULLY: I have read and understand the *Disclosure Statement* and *Notice of Privacy Practices of Counseling West Seattle*, and have had an opportunity to ask questions about them and have been given a copy of each for my records. With my consent my provider may contact me via email or text message, and I understand that these forms of communication are not HIPAA compliant. I agree to begin therapy with Counseling West Seattle for the disclosed fee, and to pay deductible and/or co-pay portions at the beginning of each session. I understand that if insurance does not cover the entire amount, I am responsible for the full cost of my treatment. CANCELLATIONS: If I am unable to keep a scheduled appointment for any reason, I must notify my provider at least 24 hours in advance or I will be charged the full amount for the allotted time.

☐ I am the parent/legal guardian of _____ and agree to the above terms on his/her behalf.

Signed: _____ Date: _____

By signing above I hereby affirm that I have read and agree to the above terms and that the information I have provided is complete and fully accurate