COUPLE & FAMILY INSTITUTE OF TRI-CITIES
8121 W. Quinault Ave Suite F202
(509) 579-0200 (509) 232-2016

CLIENT INFORMATION

Last name:	First Name	MI
Home Phone:	Work Phone:	Cell Phone:
Address:		Birth date: Age:
City:	State:	Sex: ☐ Male ☐ Female
Zip:		
Employer:		Soc. Sec. #
Address:		Prior services received at CFIT by you or family member?
City:	State:	☐ Yes ☐ No
Zip:		

PERSON COMPLETING FORM (if other than client)

Last name:		Home phone:
First name	M.I.	Work phone:

INSURANCE COMPANY INFORMATION

PLEASE READ CAREFULLY, AS THIS IS A LEGALLY BINDING FINANCIAL AGREEMENT. See our Financial Policy for further information. 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. We must have all of this information to bill. If information is not provided, services will become the responsibility of the client.

We do not bill secondary insurance.

Primary Insurance:		ID No.
Address:		Group/Plan No.
City: State	Zip:	Phone No.
Subscriber Name:		Relationship:
Address:		Birth date: Age:
City: State	Zip:	Sex: ☐ Male ☐ Female
Employer:		Soc. Sec. #

Financially Responsible Individual (**Signature On Financial Agreement Required!!**):

Name: ____

Address: ________________________ Soc Sec # __________ DOB: ____________

Employer: ________________ Phone (h) _________ Phone (w) ________________

GENERAL INFORMATION

Marital status: ☐ Single ☐ Married ☐ Other

Name of spouse/ partner:

Employment Status:
- ☐ Employed
- ☐ FT/PT student
- ☐ Unemployed

Education:
- Highest grade completed ☐
- Diploma/Degree ☐

FAMILY INFORMATION

Others who are living in your home:

Name	***Date of Birth***	***Relationship***

Religious preference: Church:

Do you or any others who are in counseling with you require special accommodations?
☐ Yes ☐ No

If yes, what type?

Are you seeking counseling with a spiritual/religious orientation?
☐ Yes ☐ No

If yes, please describe?

Prior counseling:

Therapist:	Date:	Problem:
Therapist:	Date:	Problem:
Therapist:	Date:	Problem:

Describe current problem for which you are seeking help:

Source of referral:

Emergency Contact

Name: **Relationship:** **Phone:**

Rev 12/9/2015

Couple & Family Institute of Tri-Cities

Dr. Carol Ann Conrad, EdD
Amanda Rukavina, Intern

Consent for Treatment: Mental health treatment is dependent upon many variables including an individual's hereditary makeup and environmental experiences. Each client will respond uniquely to treatment. Independent providers at the Couple & Family Institute of Tri-Cities offer qualified mental health services using widely accepted methods. We make no claims as to the anticipated results of the treatment and recognize that, in a very few individuals, treatment poses the risk of unanticipated reactions and in some cases symptoms may be alleviated through no treatment at all. Nevertheless, it is our intent to assist each client in defining problems and working towards satisfactory evaluation and/or resolution of those problems as outlined within the scope of the Individual Treatment Plan or the recommendations section of their evaluation report.

Confidentiality: Information about clients is held in strictest confidence. No information will be released without written informed consent from the client, except under specific circumstances required by the law. The Notice of Privacy Practices you will receive discusses confidentiality in more detail. Please read it carefully. In recognition of individual right to privacy when seeking evaluation and treatment, we ask you not to reveal the name or identity of any other client being seen in this office.

Client's Rights: You have the following rights as a consumer of mental health services:

- To be treated with respect and dignity
- To receive help to develop a plan of care and services that meet your unique needs
- To refuse any proposed treatment, consistent with state regulations
- To receive care that does not discriminate against you and is sensitive to your sex, race, national origin, language, age, disability, religion/spirituality, and sexual orientation.
- To be free of any sexual exploitation or harassment
- To review your case records (See Notice of Privacy Practices)
- To receive an explanation of all medication prescribed, including expected effect and side effects.
- Confidentiality as described in relevant statutes and regulations (See Notice of Privacy Practices)
- To lodge a complaint with the omsbud person, Regional Support Network (RSN) or provider, if you believe that your rights have been violated. If you lodge a complaint or grievance, you also will be entitled to a fair hearing. You shall be free of any act of retaliation. The ombud person's phone number is 1-509-735-8681 or 1-800-257-0660.
- To choose a primary care provider pursuant to WAC 275-57-1110(5)

I have read the Clients Rights and have been offered a copy of this agreement. I have been given an opportunity to ask questions regarding all proposed treatment and I agree to consent to services. I further agree that the outcome of my treatment is largely dependent upon my effort and cooperation. I indemnify and hold harmless the doctor, therapist and administration from any and all claims arising directly or indirectly from the services rendered under this agreement. Such indemnification shall include reasonable attorney fees and costs.

______________________________ ____________
Client Signature **Date**

______________________________ ____________
Financially Responsible Individual Signature **Date**

______________________________ ____________
Provider Signature **Date** Rev 6/16/17