INTAKE INFORMATION

Client Information

First Name | Middle Initial | Last Name

Mailing Address

City | State | Zip Code

( ) Cell Telephone Number | Ok to Leave Message? (Yes or No)

( ) Home Telephone Number | Ok to Leave Message? (Yes or No)

( ) Work Telephone Number | Ok to Leave Message? (Yes or No)

Email Address: _____

Would you accept our free monthly newsletter? YES / NO

/ / Social Security Number | Date of Birth | Age

Are You a Minor? YES / NO | Gender: Male / Female (please circle)

( ) Employer | Phone Number

Employer Mailing Address | City | State | Zip

Marital Status (Check one)

- ☐ Married
- ☐ Divorced
- ☐ Single
- ☐ Widowed
- ☐ Separated
- ☐ Other: _____

Spouse's Name (if applicable): _____

( ) Emergency Contact Name | Phone Number

Responsible Party Information

FSC requires a responsible party in addition to the client, unless the insured party is the client.

Payment (Check One)

☐ Insured

☐ Self-Pay

Full Name Relationship

Mailing Address

City State Zip Code

( ) ( )

Home Telephone Number Work Telephone Number

Social Security Number Date of Birth

If you do not have insurance please skip to "Assignment and Release"

Insurance Information

Primary:	Secondary:
Insurance Company Name	Insurance Company Name
Mailing Address	Mailing Address
Telephone Number	Telephone Number
ID/Policy Number	ID/Policy Number
Group Number	Group Number

Who shall we thank for the referral? _____

How did you find us? Phone Book ☐ Internet ☐

Friends/Family ☐ Other ☐

Assignment and Release

I assign my insurance benefits to be paid directly to the provider. I am financially responsible for non-covered services. I also authorize the provider to release any information required to process this claim.

We send claims to your insurance company as a courtesy. You are responsible for any unpaid balance within 30 days of receiving our bill.

X_____ **X**_____

Patient Signature Date
(Required for all patients OVER 13 years)

X_____ **X**_____

Responsible Party, Guardian, Parent Signature Date

Financial Responsibility

I understand the appointment time has been held especially for me. I also understand that missed appointments and cancelled appointments less than 48 hours in advance will be billed at 100% of the rate of each provider. Reminder calls will be made as a courtesy. _____ (Initials)

Credit Card On File

For your convenience, co payments and unpaid balances can be charged to your credit card on file. Receipt of payment will be mailed directly to you. I allow FSC to use my credit card for this purpose _____ (Initials)

Credit Card Number Expiration Date CCV

Issued Under Name (the way it appears on the card) Zip Code attached to card

Address attached to card (If different from residence)

Front Street Clinic, Inc.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record Information

Each time you visit or contact your mental health care provider, a record of this contact is made. This information, often referred to as your "chart", serves as a: 1)basis for planning your care and treatment, 2)means of communication among the many health and mental health professionals who contribute to your care, 3)legal document describing the care you received, 4)means by which you or a third-party payer can verify that services billed were actually provided, 5)a source of data for education, research, and planning, 6) a source of information for public health officials charged with improving the health of the nation, and 7) a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record (chart) and how your mental health information is used helps you to ensure its accuracy, better understand who, what, when, where, and shy others may access this information, and helps you to make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your mental health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to : 1) obtain a paper copy of the notice of privacy practices upon request, 2) request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522(a), however, we are not required to agree to such a restriction, 3) receive confidential communications of your protected health information per 45 CFR 164.522(b), 4) inspect and copy your mental health record as provided for in 45 CFR 164.524, 5) amend your record as provided in 45 CFR 164.526, 6) receive an accounting of disclosures of your mental health information as provided in 45 CFR 164.528, 7) request communications of information by alternative means or at alternative locations, 8) revoke your authorization to use or disclose mental health information except to the extent that action has already been taken.

Our Responsibilities

The Front Street Clinic is required to: 1? Maintain the privacy of your mental health information, 2) provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, 3) abide by the terms of this notice, 4) notify you if we are unable to agree to a requested restriction, 5) accommodate reasonable requests you may have to communicate information bye alternative means of at alternative locations, We will not use or disclose your information with our your authorization, except as described in this notice.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revision in our lobbies and upon request, mail a revised notice to the address you've supplied us.

Correctional Institutions: Should you be and inmate of a correctional institution, we may disclose to the institution or agents thereof, mental health information necessary for your continuity of care and the safety of you or other individuals. Furthermore, information may be released to the State monitoring program (probation) following release form a State correctional facility.

Operator of a Care Facility: We may provide information to an operator of a care facility in which you reside (nursing home, convalescent center) to assist with any special needs.

Law Enforcement/Legal Actions: We are required to report incidents of child or adult abuse or neglect and/or provide information as necessary to assist in the investigative process to the police or appropriate social service agency. We may disclose information to the Coroner or Medical Examiner, or limited information may be disclosed to law enforcement as required by law to assist in fulfilling their duties. We may disclose information upon receipt of a Court Order. Furthermore, information related to a client's commission of a crime on Front Street Clinic premises is not protected.

In the course of an investigation for involuntary treatment and/or as a result of a civil petition for involuntary treatment: We are authorized to share your information with the county prosecutor, your attorney, the court, Department of Social and Health Services, to a protection and advocacy agency, and others as allowed under the law regarding involuntary commitment proceedings, RCW 71.05 or 71.34.

Duty to Warn: We are required to disclose information to the proper authorities (law enforcement) and the intended victim if we suspect serious harm to another is intended or threatened.

Oversight: Information may be reviewed by a regulatory or oversight committee to ensure adherence to required guidelines. This may include, but not be limited to, state, federal, and regional audits reviewing business practices, billing procedures, clinical practices and confidentiality issues.

Payments/Benefits: We may disclose information to assist in collecting payment for services or to assist you in accessing benefits/aid.

Health Care Providers: We may disclose information to your primary health care provider or community mental health provider for continuity of care (unless directed otherwise), or to assist with emergency medical treatment or medically necessary tests/evaluations.

Federal law makes provision for your health information to be release to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more clients, workers, or the public.

All other uses and disclosures of your protected health information will only be made with your written authorization and you may revoke that authorization at any time as provided by 45 CFR 164.508(b)

Filing a Complaint

How to File a Complaint of Report a Problem:

If you have questions or would like additional information, of feel your privacy rights have been violated and you would like to file a complaint, you may contact the Front Street Clinic's Office Manager at (360) 697-1141. You may also file a complaint directly with the Office for Civil Rights, U.S. Dep. Of Health and Human Services, 2201 Sixth Avenue Suite 900, Seattle, WA 98121. There will be no retaliation for filing a complaint.

Effective Date: April 14, 2003

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

We keep a record of the mental health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Front Street Clinic's Office Manager.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient of legally authorized individual signature Date Time

_____ _____

Printed name if signed on behalf of the patient Relationship
(Parent, legal guardian, personal representative)

(Notation, if any, by staff)

This form will be retained in your medical record

Last Update____/____/____