



Puget Sound Psychiatric Center
 10634 E Riverside Drive, Suite 130, Bothell, WA. 98011
 Tel: (425) 806 5021 Fax: (425) 486 3949

PATIENT INFORMATION

Patient's Name		Birth Date	Social Security Number
Residence address	City	State	Zip
Home Phone			
If child, Biological parent or guardian's name	Parent's Birth Date	Parent's Social Security #	
If child, Biological parent or guardian's name	Parent's Birth Date	Parent's Social Security #	
Name of Patient's Employer (if applicable)			Business Phone
Name of Patient's Spouse (if applicable)	Birth Date	Social Security Number	
Race/Ethnicity (this is optional!) (Please circle one)	Decline to report		Preferred Language
American Indian Asian African American Hispanic White	Yes / No		

INSURANCE INFORMATION

Primary Insurance Company		
Subscriber Name	ID Number	Group Number
Secondary Insurance Company	ID Number	Group Number
Whom may we thank for referring you?		

I acknowledge that the above information is correct (Signature) _____ Date: _____

I hereby fully authorize Puget Sound Psychiatric Center and/or their agent to bill, receive, release, and exchange information with my insurance carrier.

Patient, Parent, or Guardian Signature: _____ Date: _____

If patient is 13 through 18 years old, Patient Signature _____ Date: _____

What telephone number do you wish us to leave messages at? _____

Email address: _____

Medication Allergies: _____



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www.pspc.org

PATIENT DISCLOSURE:

Office Appointment Policies:

1.	Co-Pays are due at the time of service. a) If you choose not to pay the co-pay at that time you may be charged \$50.00 service fees.
2.	Appointment should be made by contacting the office staff. a) To ensure the highest level of quality care and to monitor treatment plans, follow-up appointments should be made and kept as recommended by the clinician. b) However, it is recognized that problems can arise between appointments, in these circumstances it is advised to go to your nearest ER for any life threatening emergency; or to call to make an earlier appointment. c) Please be aware that if you have two or more NO SHOWS, you may be discharged from the clinic.
3.	The Puget Sound Psychiatric Center is a teaching and training institution for Psychiatry MD residents and Psychology PhD interns. For psychiatric treatment appointment you will be seen by a psychiatry resident as well as the Attending Psychiatrist, who is responsible for treatment decision. At times there may be a student attending your appointment with your permission. If you feel uncomfortable you may ask for the student not to be present in the appointment.
4.	Puget Sound Psychiatric Center is not an Emergency Treatment Facility.
5.	If an appointment is cancelled by the patient, the office reserves the right to charge a cancellation fee, at the following rates; a) NO FEES: Un-foreseen emergencies. b) No FEES: Cancellation more than 48 hours prior to the appointment. c) \$35.00 : Cancellation between 24 to 48 business hours before the start of the appointment. d) \$55.00 : Cancellation within 24 hours of start of the appointment.
6.	Requests for Letters: a) NO FEES: Medical necessary/ relevant to facilitate continuity of care. b) \$150.00 & up (depending on the time required to complete the letter): All other letters (must be approved and paid for in advance).

For information regarding closures due to inclement weather please refer to this website <http://www.nsd.org/Page/6483> as we run off North Shore School District.

In case of an Urgent or Life threatening emergency;

1. Call 911 or proceed to the nearest ER.
2. Do not call the office in an emergency (Calling the office may result in unforeseen and unnecessary delays in receiving appropriate emergency treatment)

Name of Patient:	Signature: (Patient or Individual legally authorized and responsible to sign consent)
Today's Date:	Relationship to Patient: (Self, Parent, Legal Guardian)



Puget Sound Psychiatric Center
 PO Box 1287
 Bothell, WA. 98041

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
 AND FINANCIAL AGREEMENT**
 (Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA))

Puget Sound Psychiatric Center ("Covered Entity") keeps a record of the 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 our Privacy Officer, at (425) 863 2818. Written requests should be made to the Privacy Officer at the following address:

Privacy Officer
 PO Box 1287
 Bothell, WA 98272
 Tel: (360) 863-2818

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.

PATIENT ACKNOWLEDGMENT:

BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

VERIFICATION OF MEDICAL CONSENT: I, the undersigned, hereby agree and consent to the plan of care proposed to me by the Covered Entity. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse medical care. I will ask for any information I want to have about my medical care and will make my wishes known to the Covered Entity and/or its staff. The covered Entity shall not be liable for the acts or omissions of independent contractors.

AUTHORIZATION TO RELEASE INFORMATION: I, the undersigned, hereby authorize the Covered Entity and/or its staff, to the extent required to assure payment, to disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payer which is liable to the Covered Entity for the Covered Entity's charges or who may be responsible for determining the necessity, appropriateness, or amount related to the Covered Entity's treatment or charges, including medical service companies, insurance companies, workmen's compensation carriers, Social Security Administration, intermediaries, and the State Department of Health and Human Services when the patient is a Medicaid or Medicare recipient. This consent shall expire upon final payment relative to my care.

FINANCIAL AGREEMENT:

PRIVATE PAY: I, the undersigned, hereby agree, whether signing as agent or as a patient, to be financially responsible to the Covered Entity for charges not paid by insurance. I understand this amount is due upon billing.

INSURANCE COVERAGE: I certify that the information given to me in applying for payment under government or private insurance is correct. I hereby assign payment directly to the Covered Entity for benefits otherwise payable to me. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within thirty (30) days of invoice. I understand the Covered Entity will verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all non-covered charges. I understand that it is my responsibility to determine the coverage limits of my insurance.

I understand a minimum monthly fee of 1% (annual rate of 12%) may be charged for late payment on all balances not covered by insurance. This is in addition to a charge for reasonable attorney fees, court costs, and collection agency expenses incurred to collect the amount due.

 Patient or legally authorized individual signature

 Date

 Time

 Printed name if signed on behalf of the patient

 Relationship
 (Parent, legal guardian, personal representative)

AS A COURTESY TO YOU WE VERIFY YOUR BENEFITS.

PLEASE BE AWARE THAT THE INSURANCE COMPANIES AND
MANAGED CARE COMPANIES DO NOT GUARANTEE THAT THE
INFORMATION THEY GIVE US IS CORRECT, THEREFORE WE CAN NOT
GUARANTEE THIS INFORMATION EITHER.

PATIENT SIGNATURE

DATE

PARENT OR GUARDIAN SIGNATURE

DATE

Puget Sound Psychiatric Center PS

Patient Name: _____

I give permission for my appointment date(s), time(s) to be shared with the following people:

Please print

Relationship to patient

Please print

Relationship to patient

Please print

Relationship to patient

Please print

Relationship to patient

Signature

Date

Parent or Guardian

Date