PATIENT REGISTRATION

Patient Name: _____Gender: _____ D.O.B____/_____/_____

Address_____

City/State_____Zip Code:_____Social Security #_____

(Primary Contact Number):_____ (Secondary Contact Number):_____

E-Mail Address: _____Permission to use Cell Phone/E-mail to leave a message: Yes: __ No __

Employer/School: _____Work Number _____

Doctor/Pediatrician:_____Phone:_____

Parents Name (if patient is a child) _____

Have you had a different last name, Maiden Name? Please list: _____

Family member who has received care at this Clinic? _____ Relationship:_____

WHO IS RESPONSIBLE FOR PATIENT'S MEDICAL EXPENSES?

Parent Spouse Self Parent or Spouse's Name:_____

Street address: _____ Zip: _____
Social Security#_____

IF LABOR AND INDUSTRIES CLAIM

Case Manager: _____Claim Number:_____Date of Injury:_____

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IMPORTANT INFORMATION REGARDING YOUR BILLING ACCOUNT

It is important that you understand that we will not discuss your account with anyone other than you unless you provide us with written instructions to do so. Information about your account with us is confidential. If someone other than you calls with a question about your account, even to make a payment, we will not talk with them unless their name appears on the list below.

Please take a few minutes to consider this issue carefully and then complete and sign the section below.

☐ I do not want you to discuss my account with anyone other than me.

☐ I give you my permission to discuss my billing account with the following person(s).

NAME OF PERSON RELATIONSHIP TO YOU

_____ _____

Your signature: _____ Today's date_____

Please Complete Both Sides of This Form

Rainier Behavioral Health Financial Policy

Rainier Behavioral Health is committed to providing you with the quality care that you expect and deserve from a professional behavioral health practice. Please ask us any questions you have about the billing process.

Often the assumption is made that if a person has insurance, then it is the insurance company who owes the doctor for their services. As the insurance contract is between you and the insurance company alone, it is you who are responsible for the bill, regardless of insurance coverage determination. We are happy to bill your primary or secondary insurance company for you as a courtesy. **Please keep in mind that the responsibility for the payment remains with the patient.**

IF YOU ARE COVERED BY INSURANCE

Clients with insurance are expected to make (copays) and determined deductible amounts at the time of service. This amount is based on an estimate of the portion not covered by your insurance. It is your responsibility to know the terms of your insurance coverage, as well as any exclusion, limitations, deductibles and copays. We do our best to provide you with the information we gather from your insurance carrier but it is not a guarantee of payment from your insurance carrier.

IF YOU ARE NOT COVERED BY INSURANCE

Patients without insurance are expected to make payment in full for all charges at the time of service. If you pay **in-full** at the time of services, a 10% discount will apply for cash or check payments and a 5% discount will apply for any payment made by credit card. Keep in mind that sessions with the clinician may change in the type of treatment i.e. Therapy, therapy with medication management, just medication management, etc. This may result in different session fees. If you have any questions regarding the type of sessions you are receiving, please do not hesitate to ask.

PAYMENT OPTIONS

Payments may be made with Visa, MasterCard, Debit Card, cash, money order or personal check. There will be a $40.00 fee on all returned checks unpaid by your bank. Delinquent accounts may be referred to a collection agency after 120 days unless previous arrangements have been made.

PAST DUE ACCOUNTS

As a valued client we will work with you to clear up overdue accounts however; we reserve the right to utilize a collection agency for further recovery efforts. If patients are sent to collections for unpaid charges, they will be terminated from the practice.

AUTHORIZATION

With my signature below, I hereby authorize release of any relevant information necessary to process my claim to my insurance company. I also authorize any insurance benefits otherwise payable to me to be paid directly to Rainier Associates for providing the services.

ACKNOWLEDGEMENT

I acknowledge I have read the financial policy above and that I am responsible for all charges regardless of any insurance coverage I have. I understand that delinquent accounts may be assigned to a credit reporting collection agency and agree to pay for all legal costs and expenses including reasonable attorney fees.

_____

Print Name

_____ _____

Signature of Responsible Party Date

Please Complete Both Sides of This Form

Notice of Privacy Practices Acknowledgment

Rainier Behavioral Health has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact Rainier Behavioral Health at: 253-475-6021 to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of Rainier Behavioral Health.

_____

Printed name of patient

_____

Patient or legally authorized individual's signature Date

_____

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

*This form will be retained in your medical record.

For Office Use Only

Office staff complete below:
I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: _____ Staff member initials: _____

Reasons: _____

_____

Rainier Behavioral Health Appointment Reminder Program

If you choose not to use the system please fill in the appropriate check mark by the, "no I do not want you to contact me for an appointment reminder". This information is only for the appointment reminder system.

Your name: _____
(Please print)

Would you like to receive an appointment reminder call, email, or Text? (Please circle one)
Yes _____ **No** _____

If **yes** please supply only the phone number you would like us to contact you with:
Home: _____ Cell: _____ Work: _____

Please print email address clearly if you would like us to contact you also by email:

_____

Patient Signature: _____ Date: _____

Please Complete Both Sides of This Form

Obtaining Verbal/Written **PERMISSION** to Use or Disclose Protected Health Information
As stipulated by the Title 45, Section 164.10, we are permitted to make such uses or disclosures after we have obtained your verbal or written permission.

RAINIER BEHAVIORAL HEALTH IS AUTHORIZED TO: (Please check all that apply.)

_____Notify or speak with my spouse regarding treatment or proposed treatment.
(Please specify name) _____
_____ Notify or speak to my caregiver regarding treatment or proposed treatment.
(Please specify name) _____
_____ Notify or speak to my family members, i.e., children, sister, brother, mother, father of treatment or proposed treatment. (Please specify names): _____
_____ Notify or speak to my friend regarding treatment or proposed treatment.
(Please specify name): _____
*How may we contact you with reference to your appointment, proposed treatment, follow-up appointments, billing question/problems and other situation regarding your protected health information? See below:

If I am not available Rainier Behavioral Health may: (please check all that apply)

___ Leave a message with my spouse or those members listed above
___ Leave a message on my answering machine, voice mail or cell phone.
___ Call my place of employment and leave a message for me to return the call.
___ Leave a message with my referring doctor's office to have me return the call.
___ Leave a message with my interpreter (for foreign speaking patients)

Request For **RESTRICTIONS** On Use Or **DISCLOSURES** Of Protected Health Information

****NOTE: THIS FORM ONLY NEEDS TO BE COMPLETED IF YOU WISH TO REQUEST ANY OF THE RESTRICTIONS LISTED BELOW.***

- I understand that I have the right to request certain restrictions on the use or disclosure of protected health information (PHI) about me. I request that Rainier Associates.
- Restrict the use or disclosure of PHI about me for the purpose of treatment, payment, and health care operations for those items I have checked:
- Restrict disclosures to family members, other relatives, my close personal friends, or other persons, all of whom are identified below, of PHI about me.

____ I request that my PHI not be disclosed to the following individuals or persons:
_____

____I request that the restrictions indicated above apply to the following information:
_____

Both you and Rainier Behavioral Health must agree and sign your restriction request for it to be effective. Restrictions requested does not apply to uses or disclosures of my PHI by any other health care providers. Either party may terminate the restrictions by notifying the other party in writing.
Rainier Behavioral Health is required by law to void this agreement for purposed of emergency care, reported threats to yourself or others and investigation of Rainier Behavioral Health's compliance with the HIPPA Privacy Rule.

_____

Patients or Legally Authorized signature Print Name Date

_____

Printed Name if signed on Behalf of Patient Relationship

Please Complete Both Sides of This Form

OPTIONAL CARD AUTHORIZATION FORM

PLEASE COMPLETE THIS FORM TO ENABLE US TO PROCESS CHARGES FOR:

CO-PAYMENT

CO-INSURANCE AFTER YOUR INSURANCE HAS PAID YOUR VISIT

NO SHOW FEE

I authorize: Rainier Behavioral Health

To charge my credit card for $ Applicable Charges

Patients Name: _____

Customer's name: _____

Card holders name: _____

Card holders address: _____

City: _____ State: _____ Zip: _____

_____Visa _____MasterCard ____ Discover

Account Number: _____ _

CVV2: _____
(3 digits found on the back of the card in the signature line- Visa, MasterCard, Discover)

Expiration Date: _____

Signature: _____

Today's Date: _____

Note: Your credit card will be processed the day after your visit with exception of co- insurance; the balance will be processed to your credit card after your insurance payment has been applied to your account.

Please Complete Both Sides of This Form

RAINIER BEHAVIORAL HEALTH

Barry Anton, Ph.D., ABPP
Trenton Williams, Ph.D.
Catherine Mulhall, M.S.W.
Jodi Howell-Nagy, Ph.D.
Stephanie Munizza, LMFT, CDP.
Natalie Glover, Ph.D.
Emily Schoenfelder, M.S.W.
Susan Poole, Ph.D.
Vanessa Honn, Ph.D.
Amy Dwyer, LICW
Thomas Roe, Psy. D.
Kirstin Kirschner, M.D.
Fletcher Taylor, M.D.
George Jackson, M.D.
Ryan Coon, Psy. D.
E. Thomas Dowd, Ph.D., ABPP
Marsha Cain, M.D.

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Rainier Behavioral Health, reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

Please Complete Both Sides of This Form

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE PERSON WHO WILL BE RECEIVING TREATMENT AT RAINIER ASSOCIATES

CURRENT MEDICAL CONDITIONS:

_____ _____

_____ _____

_____ _____

CURRENT MEDICATIONS:

Name of medication Dosage Prescribing Physician

_____

_____

_____

_____

_____

CURRENT HEALTH CARE PROVIDERS:

_____ _____

_____ _____

_____ _____

_____ _____

Please Complete Both Sides of This Form