Mind, Body, Heart & Spirit

Wellness ♦ Personal & Professional Growth ♦ Community Development

CHANI PHILLIPS, PH.D.

CLIENT INFORMATION FORM

(Please Print)

CLIENT INFORMATION

Client's Last Name:	First:	Middle:	Social Security no.:
Spouse/Partner's Name	(Former Name):	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Street Address and P.O. Box:		Home Phone no.:	Cell Phone no.:
City:	State:	ZIP Code:	Marital Status (circle one) Single / Mar / Div / Sep / Widow
E-mail Address ***(Your monthly statement may be sent here):***			
Occupation: (Full or Part-time?)	Employer Name & Address:		Work Phone no.:

Ethnicity: ❑-Native Amer (Tribe:_____) ❑-White ❑-Hispanic ❑-African Amer ❑-Asian ❑-Other:_____

Other family members seen here:			Who Referred You?
Person responsible for bill (if different):	Birth date: / /	Address (if different):	Home Phone no.:
Employer:	Employer Address:		Employer Phone no.:

PAYMENT INFORMATION

WHO WILL PAY FOR CLIENT SERVICES?

❑ - **SELF-PAY** - Full payment is due in cash or check on the day of services. Please write checks before your session, to: Chani Phillips, Ph.D.

❑ - **INSURANCE** - Please pay your copay (client responsibility) on day of services to: Chani Phillips, Ph.D.

❑ - **YAKAMA NATION CONTRACT HEALTH SERVICES – CLIENT'S IHS CHART #:**_____
Within 48 hours before or after each appointment, you must call your IHS claims examiner at Contract Health: 865-3808 or (800)-922-7006 to notify them of the dates you came for counseling.

❑ - **DCFS – Yak / Topp** **Case Worker:** _____ **Tel:** _____ **Case#:** _____.

❑ - **EAP - Employee Assistance Program:** _____ **Tel:** _____.

INSURANCE INFORMATION

Name of **PRIMARY INSURANCE**:			Insurance Phone no: ( )		
Subscriber's Name:	Subscriber's ID no.:	Group no.:	Subscriber's S.S. no.:	Birth Date: / /	Co-payment: $
Subscriber's Address: ❑ Same as above		Subscriber's Phone:	Client's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		
Subscriber's Employer: ❑Same as above	Employer Address: ❑ Same as above			Employer Phone no.:	

Name of **SECONDARY INSURANCE** (if applicable):			Insurance Phone no:		
Subscriber Name:	Subscriber's ID no.:	Group no.:	Subscriber's S.S. no.:	Birth Date: / /	Co-payment: $
Subscriber's Address:		Subscriber's Phone:	Client's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		
Subscriber's Employer: ❑Same as above	Employer Address: ❑ Same as above			Employer Phone no.:	

TO SCHEDULE APPOINTMENTS: CALL 966-1700

Please note that if you have a need to cancel or reschedule an appointment, please be sure to call at least 24 weekday hours in advance of your scheduled appointment time or you will be billed full session fees (e.g. Monday appointments need to be rescheduled by the prior Friday), and insurance does not pay for late cancellations or missed appointments.

_____ ***YOUR INITIALS HERE*** **- INDICATE YOU AGREE TO PAY FULL FEE FOR SESSIONS NOT CANCELLED OR RESCHEDULED AT LEAST 24 WEEKDAY HOURS IN ADVANCE.**
Insurance and other payors will not pay for these late cancellation sessions.

IN CASE OF EMERGENCY

Name & address of local friend or relative (not living at same address):	Relationship to Client:	Home Phone:	Work Phone:

AGREEMENT TO ALL OF THE POLICIES:

WASHINGTON STATE HIPPA REGULATIONS REQUIRE THAT WE OBTAIN YOUR SIGNATURE WHICH INDICATES THAT YOU HAVE RECEIVED AND READ THE FOLLOWING AGREEMENTS AND AGREE TO ALL OF THEIR TERMS IN THE:

"The Psychotherapist-Patient Services Agreement for Washington State & HIPAA Notice"

Your signature below indicates that you have read, understand, and fully agree to the policies for these services as provided in: "The Psychotherapist-Patient Services Agreement for Washington State & HIPAA Notice". If you have any questions, please feel free to discuss these with me before signing this form. Your signature below also indicates that you give consent for psychotherapy services for yourself and/or the other clients involved in sessions. You agree to pay for all services rendered, sessions that are failed or not cancelled within 24 weekday hours of the appointment, applicable late fees, and all legal fees incurred in collection of delinquent accounts. You give us authorization to email or mail your monthly statement or any correspondence to your information provided above, and will be responsible to contact our office if your email or mailing addresses change. Your signature authorizes the release of any medical or other information necessary to process insurance claims or collect on accounts, and authorizes your insurance to assign and pay benefits directly to this provider. You are responsible to pay the balance in full in the event that your insurance or other primary payor denies payment for any reason. A late fee of $25 per month will be charged on late payments received after the 20th of each month, and a finance charge of 1% will be charged monthly on any outstanding balance.

PRINT CLIENT NAME: _____ Date: _____

CLIENT (or GUARDIAN) SIGNATURE: _____

WITNESS: _____
Chani Phillips, Ph.D. - Licensed Mental Health Counselor

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(FOR OFFICE USE) BILLING NOTES:

Best Appt Times =_____ DX CODE:_____

Ins Effective:_____ TX Auth Required= Yes/No Completed:_____ Auth #_____ # Sessions=_____

Deductible=_____ Indiv/Fam # Sessions =____ Copay =_____ Co-Insurance =_____ Client Resp =_____

DCFS Authorization Date=_____ TX Authorized= _____ # Sessions=____ /____ From_____ to _____

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