Individual Data

Date ____________________Sex: Male ___ Female ___ SS# ______________________

Client Name ________________________________Date of Birth ____________________

Address ____

City / State / Zip ____

Phone: Home _________________________ OK to call you at Home? ______________

Phone: Work __________________________ OK to call you at Work? ______________

Name of Spouse or Partner (if applicable) ____

Person to Contact in Event of Emergency ____________________________Phone # _______________

Guarantor Information (complete only if not client)

Person Responsible For Payment ____

Billing Address ____

City / State / Zip ____

Phone ______________________ Work ______________________ SS# ______________________

Relationship to Client _________________________________Employer ____________________________

Insurance Information (please provide your card for photocopy)

Name of Insurance Company ____________________________________

Address ____Phone______________________

Insured _________________________________ Relationship to Client _______________________________

Policy # ______________________Group # ________________________ ID# _________________________

Is This a Managed Care Plan? YES ___ NO ___ Have You Obtained Authorization? YES ___ NO ___

1611 116th Ave. NE, Suite 224 • Bellevue, WA 98004 • Ph. 425.283.1313 • Fax 425.283.1316 • Toll-free 866.297.7960

EAP Services Contract

CoHear, Inc. (CoHear) agrees to provide consultation, assessment, and referral services on the terms set forth below. The client agrees to these terms:

SERVICES
The employee is entitled to a maximum of ____ sessions of consultation, assessment of referral per year, CoHear will furnish three community referrals, one of which, if appropriate, may be CoHear.

CANCELLATION
If any appointment is canceled by the client with less than twenty-four (24) hours notice, one session will be deducted from the client's contract. If the appointment is canceled by CoHear with less than twenty-four (24) hours notice, the client shall receive a credit of one substitute session.

CONFIDENTIALITY
Matters which are disclosed to CoHear by the client will not be shared with any third party without the prior written consent of the client, unless required by law, ie. when a threat to the safety of client or others is involved (please see our Statement of Confidentiality).

RESPONSIBILITY
CoHear understands and respects its full responsibility for the delivery of its professional services and the client hereby acknowledges individual responsibility for his/her own personal growth as the client.

Date ______________________

Client Name (please print) ____________________________

Client Signature ________________________________

CoHear Consultant _____________________________

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CoHear
Helping Everyone Achieve Results

Statement of Confidentiality

Our policy at CoHear is that all information given by a client in an individual session with a therapist/counselor is confidential and will not be revealed to any person or agency without the client's written release. The laws of Washington State are more lenient than our company policy. However, it is our philosophy and policy to uphold the maximum client confidentiality possible, under the laws.

Washington State law requires healthcare professionals to reveal information to others, with or without the client's permission, in the following situations. Our policy is to inform the client if at all possible before reporting such a situation.

a. If a client intends grave bodily harm to another person.
b. If a client intends grave bodily harm to him/herself.
c. If a court of law issues a court order to reveal information.

If a situation of current child abuse, elderly abuse, or abuse to a developmentally disabled person is revealed. CoHear's policy further applies to reporting child abuse, elderly abuse, or abuse to a developmentally disabled person which has occurred not only currently, but at any time.

A healthcare provider may disclose healthcare information about a patient without the patient's authorization to the extent a recipient needs to know the information, if the disclosure is to:

a. A person who the provider reasonably believes is providing healthcare to the patient; or
b. Members of the patient's immediate family, or any other individual with whom the patient is known to have a close personal relationship.

There are several other circumstances in which people may obtain your records. Under this law, if the patient wishes to not have their healthcare information disclosed they are to sign a form stating that they do not wish to have their healthcare information disclosed without written consent.

CoHear keeps a record of the healthcare services we provide you.You may ask us to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law compels us to do so. You may also ask us to correct that record.You may see your record or get more information about it from your therapist.

I have read and fully understand this statement of confidentiality.

________________________________ ________________

Client/Guardian/Client Representative Date

________________________________ ________________

Witness Date

Name of Managed Care Company ____

Do You Have a Referral From Your Primary Care Physician? YES ___ NO ___

Name of Primary Care Physician ______________________________Phone ___________________

Medical Information

Current Medications ____

Pertinent Medical History ____

____

____

Referral Source

Name of Person Who Referred You To This Office __________________________________

Signature of Client or Guardian ____

Acknowledgement of Receipt of Notice of Privacy Practices

Patients Name: ___________________________________ Patient ID# ____________________

I hereby acknowledge that I have received a copy of CoHear's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____ ______________________

Signature of Patient or Legal Representative Date

____ ______________________

Printed Name of Patient's Representative (if applicable) Relation to Patient (if applicable)

____ Parent or Guardian of unemancipated minor
____ Court appointed guardian
____ Executor or administrator of decedent's estate
____ Power of Attorney

- -

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Paractices on the following date, ________________ but acknowledgement could not be obtained because:

___ Patient/Representative refused to sign
___ Emergency situation prevented us from obtaining acknowledgement at this time
(will attempt again at a later time)
___ Communication barriers prohibited obtaining acknowledgement (Explain) __________________

____

____

____

___ Other (Specify) ____

____

____

____

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Authorization For Release of Health Care Information

I, ____, hereby give my consent for:

____to;
(Thereapist's Name

___ Release Information ___ Exchange Information with
___ Obtain Information from ___ Other

To/With/From:

Name: ____

Address: ____

Phone: ___________________________ Fax: _________________________________

Description of Information to be released: ____

____

Purpose of disclosure: ____

____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Signature of Client: ____

SS#: ____________________________ Date of Birth: _______________________

Dated: _______________________________

This authorization will expire on __________________ or in ninety (90) days, whichever comes first, and may be revoked at any anytime.

Witness Signature ____ Date __________________

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Questions To Ask A Potential Therapist

1. My concerns or problems are...

2. What would your approach be in working with me?

3. How long have you been in practice? Briefly describe your experience.

4. How much of your practice consists of working with people with similar kinds of problems as mine?

5. How successful have you have been at helping people with my problem?

6. Do you believe family members should be involved at any point in my treatment?

7. What are your credentials (degree, license, certifications, etc.)?

8. What are your thoughts about medication?

9. What is your fee schedule?

It is perfectly acceptable to be assertive and cautious
when you make this important choice. Trust your "hunch"

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