THREE RIVERS THERAPY

10505 W CLEARWATER AVE KENNEWICK WA 99336

CONSENT FOR TREATMENT

_________Initial **I have been provided with a copy of the HIPAA Notice of Privacy Practices and I understand the ways in which my medical information may be used and/or disclosed. I also understand that though Three Rivers Therapy will not intentionally share my personal information, electronic communication such as email, text messaging, etc is not a secure form of communication and my provider cannot guarantee confidentiality if I choose to contact them electronically.**

_________Initial **I understand that I am responsible for paying co-pays/co-insurance in full at the time of service; I also understand that it is my responsibility to provide accurate and up to date insurance information for billing purposes, and that I will be billed for the full amount due if the information I give is inaccurate or expired.**

_________Initial **I am aware of the clinic's policy on cancellations and no-shows; if I miss an appointment without giving 24 hours' notice, I will be removed from my providers schedule and may not be able to reschedule.**

IF THE PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING AND SIGN TO CONFIRM CONSENT FOR THEIR TREATMENT

Parent/Legal Guardian Name ________________________________ Relationship to Patient ______________________________

Address ____ City _________________________State _________ Zip ___________

Phone 1______________________ Phone 2_____________________________ Email _______________________________________

BY SIGNING BELOW, I UNDERSTAND THAT I AM GIVING CONSENT FOR THE MEDICAL CARE OF MY MINOR CHILD. I AM THE PARENT OR LEGAL GUARDIAN OF THE PATIENT IDENTIFIED BELOW AND CONFIRM THAT I AM AUTHORIZED TO MAKE MEDICAL DECISIONS ON THEIR BEHALF. I AGREE TO THE TERMS OF TREATMENT, INCLUDING BUT NOT LIMITED TO PRIVACY POLICIES, PAYMENT FOR SERVICES, AND CANCELATION POLICIES.

PATIENT DEMOGRAPHICS

Name ______________________________________ Date of Birth _____/_____/_____ Social Security Number ________________

Address ____ City _________________________State _________ Zip ___________

Phone 1______________________ Phone 2_____________________________ Email _______________________________________

Occupation _________________________ ☐ part time ☐ full time military service ☐ yes ☐ no student ☐ yes ☐ no

gender identity: ☐ male ☐ female ☐ non-binary ☐ other
relationship status: ☐ in a relationship ☐ single ☐ married ☐ divorced
sexual orientation: ☐ homosexual ☐ heterosexual ☐ bi-sexual ☐ other

EMERGENCY CONTACT

Name ______________________________ Phone ______________________ Relationship ________________________________

________ Initial **I understand that should emergency services be needed, including that of crisis response, the emergency contact I have listed above will be notified.**

HEALTH HISTORY

Primary Care Physician ______________________________ ☐ Trios ☐ Kadlec ☐ Lourdes ☐ Other _____________________

Referring Provider ___________________________________ Reason for Referral __________________________________

Patient Signature _________________________________ **Parent/Guardian Signature** ___________________________

Date Signed __________/______________/_____________ **Parent/Guardian Name** ______________________________