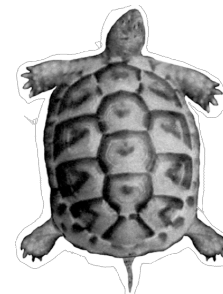


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Welcome To Our Services

The following information is needed to meet State information and Insurance requirements:

Section 1 - Patient Information

Name _____ Date Of Birth _____ - _____ - _____ Age _____ Gender M of F

Address _____ City _____ State _____ Zip _____

Home _____ - _____ - _____ Work _____ - _____ - _____ Mobile _____ - _____ - _____

Best Number to call? _____ Best time to call? _____ OK to call Home?:? OK to call Work?:?

Youth Single Married Separated Divorced SSN _____ - _____ - _____

Occupation _____ Employer or School _____

Referred by _____ May I thank them? Yes No

Primary Care Physician _____ Address _____ Phone _____ - _____ - _____

If the Patient is under 13 years old, please complete Section 2

Section 2 - Parent and/or Guardian Information

Name _____ Date Of Birth _____ - _____ - _____ Age _____ Gender M of F

Address _____ City _____ State _____ Zip _____

Home _____ - _____ - _____ Work _____ - _____ - _____ Mobile _____ - _____ - _____

Best Number to call? _____ Best time to call? _____ OK to call Home?:? OK to call Work?:?

Youth Single Married Separated Divorced SSN _____ - _____ - _____

Occupation _____ Employer or School _____

Section 3 - Fee and Payment Information

PAYOR: Self Third Party: Insurance * DCFS ARIS Tribal

*PLEASE PROVIDE YOUR INSURANCE CARD TO BE COPIED FOR YOUR FILE.

Third Party Portion Est. \$ _____ Client Portion Est. \$ _____ Total Fee Per Session Est. \$ _____ *

Section 4 - Missed Appointments and Late Cancellations

(Third party payers will not cover any part of the cost of an appointment that is either missed or canceled with less than 24 hours notice.)

THERAPIST'S STATEMENT: When you and I schedule an appointment I am setting aside a part of my schedule to do urgent work for you at your request. This is a very important commitment to me.

CLIENT'S STATEMENT: I understand and agree that I am personally responsible for paying \$60.00 for each missed appointment and each appointment canceled within 24 hours of the scheduled time. I understand that I am also responsible for any additional costs for collection if necessary. I understand that our insurance processing and billing service will process all personal information confidentially.

Signed _____ Date _____ - _____ - _____

SKAGIT FAMILY STUDY CENTER