



Karma Brooks, LCSW
852 SW 21st Ave
Portland, OR 97207

Phone: 503-351-7969
Fax: 503-477-9651

Confidential Patient Information

Today's Date _____

Name _____
Last Name First Name Initial

Date of Birth _____ Age _____

Home Phone _____ Work Phone _____ Other Phone _____

OK to Leave Messages at Which of the Above? _____

Home Address _____ City _____ State _____

Zip _____ How long at this address? _____

Driver's License # & State _____ E-mailAddress _____

Responsible Party (for minors) _____ Date of Birth _____ Age _____

Employer _____ Occupation _____

Employer's Address _____

Partner's / Spouse's Name _____ Partner's Date of Birth _____

Partner's Employer _____ Partner's Occupation _____

Partner's Business Address _____

Person to Contact in Case of Emergency _____ Relationship _____

Emergency Contact Home Phone _____ Work Phone _____ Other Phone _____

Primary Care Physician _____ Phone _____

Pharmacy _____ Phone _____

Who May I Thank For Referring You? _____



Karma Brooks, LCSW
852 SW 21st Ave
Portland, OR 97207

Phone: 503-351-7969
Fax: 503-477-9651

Office Policies

Thank you for asking me to participate in your health care. The following discusses the policies and procedures of this office. Please read them carefully, and ask me any questions you may have before signing this agreement.

1. **Phone calls:** I regularly return phone calls Monday through Friday, and attempt to return calls in a timely manner-by the next business day. Please leave your phone number with your message.
2. **Emergencies:** If you have an emergency, please call my cell phone number. During the week I am usually on call and available by cell phone. If your emergency cannot wait for a call back, please call Multnomah County Crisis Line at (503) 988-4888 or go to the nearest Hospital Emergency Room.
3. **Cancellation policy:** If you need to cancel an appointment for any reason, I will need 24 hours notice. Appointments not cancelled 24 hours in advance will be charged to you at full fee. **Insurance will not pay for missed appointments.**
4. **Billing:** The following billing policies apply:
 - a. Unless the patient is using Regence Blue Cross / Blue Shield for insurance, fees for initial intake appointments are due at the time of service.
 - b. Fees for follow-up visits are due at the time of service. If you are using insurance, claims for services will be sent to your insurance company. Please note that co-payments, co-insurance (for example, if you are required to pay a percentage), amounts toward your deductible, and any visits not covered are due upon receipt of your account statement. Your account statement may be paid by check, money order, credit card, or cash. A late fee of \$10 applies monthly.
 - c. In the event we are unable to collect on your account, be advised that uncollected fees will be turned over to the office's collection agency. Only necessary information will be released to them. Please be assured that we will make every effort to work with you before this happens.

Credit/Debit Card Option:

If you prefer to use a credit or debit card for payment, please fill out the following lines and sign below. Please remember all visits (including missed visit charges) will be billed to this card after each visit until payment method changes at your request.

Card type _____ Card Number _____ Exp date _____ Verification Code _____

Agreement

I have read the above office policies and procedures, and my questions have been answered appropriately. I agree to adhere to the above policies.

Client's signature _____ (or responsible party if minor)

Date _____



Karma Brooks, LCSW
852 SW 21st Ave
Portland, OR 97207

Phone: 503-351-7969
Fax: 503-477-9651

Insurance Information

Primary Insurance _____

Address _____

Contact Phone Number for Benefits _____

Name of Insured _____

Group Number _____ Identification or Policy Number _____

Secondary Insurance _____

Address _____

Contact Phone Number for Benefits _____

Name of Insured _____ Relationship to Insured _____

Group Number _____ Identification or Policy Number _____

Authorization to Release Information and Assignment of Insurance Benefits

I hereby authorize Karma Brooks, LCSW to:

- 1) Furnish my insurance company with any/all information requested concerning my present claim(s).
- 2) Bill my insurance company, and to accept payment from that company on my behalf, for all services from time to time relating to my care.

I acknowledge that I am responsible for all charges not covered by my insurance. I understand that any money received from my insurance company by Karma Brooks, LCSW, in excess of my bill will be refunded to me after completion of treatment. I also understand that I will be charged for any appointment I fail to keep or cancel 24 hours prior to the appointment time and I agree to pay these charges in full.

Client's signature

Date

Responsible party's signature if patient is a minor