

Cynthia Benson MS, LMFT, NCAC II
8121 W Quinault Ave STE F202, Kennewick, WA 99336
(509)579-0202 Office – (509)232-0216 Fax

Referred by: Physician: _____ Friend: _____ Psychology Today
Internet/Other

Name: _____ Date of Birth: ____/____/____
 First Middle Last

Address: _____
 Street City State Zip

Please Check One: Male Female Social Security # _____ - _____ - _____

Telephone: _____ May we leave a message on this number Yes No

Cell: _____ May we leave a message on this number Yes
No

Marital Status: _____ E-Mail Address: _____

If under 18: Mother's/Father's name: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Credit or Debit Card # to keep on file: _____ Expiration Date: ____/____/____ CVC: _____

Name on above card: _____

*Card uploaded to secure software and then this form is shredded. *Card will be charged within 48 business hours after visit.

Name of Referring Physician: _____

Address: _____ Phone # _____

Insurance:

Primary Insurance: _____ Policy #: _____ Group: _____

Policy Holders Full Name: _____ Male
Female

Policy Holders Date of Birth: ____/____/____ Relationship to Client: _____

Social Security #: _____ - _____ - _____ Address: _____

***Notice of Privacy Practice Patient Acknowledgement:**

I have received and/or reviewed this Office's Notice of Privacy Practices. The notice provides details about uses and disclosures of my protected health information that may be needed by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at/or controlled by the practice. I understand that I may obtain this practice's current Notice of Privacy Practices upon request.

***Release of Information:**

Your clinician is not allowed to release information to anyone but the patient. If you would like our office to be able to discuss anything with anyone besides yourself, please indicate this below:

- Only myself
- Other: _____ What: _____ Relationship: _____

By signing below I acknowledge that I have read and understand the above information, Please feel free to ask any questions.

Signature: _____ Date: ____/____/____
(If you are younger than 18 years of age, forms must be signed by parent or guardian)

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Family Information:

Others who are living in your home:

Name	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Religious Preference: _____ Church: _____

Do you or any others who are in counseling with you require special accommodation? Yes No

If yes, what type? _____

Are you seeking counseling with a spiritual/religious orientation? Yes No

If yes, please describe? _____

Prior Counseling:

Therapist: _____	Date: _____	Problem: _____
Therapist: _____	Date: _____	Problem: _____
Therapist: _____	Date: _____	Problem: _____

Describe current problem for which you are seeking help: _____

Please read carefully, as this is a legally binding financial agreement. We will bill your primary insurance if an insurance card is provided as a **courtesy** to you. Services denied due to missing or incorrect information are **client's responsibility**. Please verify any **pre-authorization requirements** and policy limitations for mental health services. Claims over 90 days will be applied to the client's balance. If insurance information is not provided, services will become the responsibility of the client.

We do not bill secondary insurance.

Missed appointments/Late cancellations: All evaluations and treatment visits are by appointment only. An appointment is a commitment to work together at a designated time and place. **Clients who fail to attend a scheduled appointment, or cancel after 10 am two (2) business days prior to their scheduled appointment, will be charged a fee (current up to the full amount of the session) Regardless of the reason for the no show or late cancellation.**

Signature: _____ Date: ____/____/____