Patient Information			
Full Name	DOB	Today's Date	
Address	City	State	Zip
SSN	Phone	Email	
I Authorize SBHP to Leave Detailed Voice Messages at the Above Number: ☐ Yes ☐ No Text Reminders: ☐ Yes ☐ No			
Legal Sex	Gender	Pronouns	Marital Status: ☐Single ☐Married ☐Widowed
Emergency Contact	Relationship	Phone	
Ethnicity: ☐ Hispanic/Latino ☐ Mexican ☐ Mexican American ☐ Non-Hispanic or Latino			
Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American/American Indian ☐ Alaska Native ☐ Hawaiian/Pacific Islander ☐ Other:			
Are you a Stillaguamish Tribal Member or Relative? ☐ Yes ☐ No	Other Tribal Affiliation		
Employer ☐Full Time ☐Part Time			
Primary Care Provider	Location		
Are you: ☐ Deaf/Heard of Hearing ☐ Blind/Vision Impaired	Interpreter Needed: ☐No ☐Yes: ☐ASL ☐Other:		

Referral Information			
Are You Court or Probation Ordered to Complete an Assessment?		Yes	No
If Yes, Case Number	Jurisdiction		
Are You Under Supervision by the Department of Corrections?		Yes	No
If Yes, Correction Officer's Name	Phone		
Do You Need to Report an Assessment to the Department of Licensing?		Yes	No
Are you Involved with ICW, DCYF, Family Court or Open Guardianship Case?		Yes	No
If Yes, Assigned Case Worker	Phone		
Are You a Registered Sex Offender or Do You Have Any Pending Charges of This Nature?		Yes	No

Billing Information		
Primary Insurance	ID Number	Group Number
Subscriber Name		Subscriber DOB
Secondary Insurance	ID Number	Group Number
Subscriber Name		Subscriber DOB

Consent to Bill

I authorize SBHP to file a claim with my insurance carrier for services rendered. I understand that I am responsible for any part of the charges that are not covered/paid by my insurance and I will be billed directly for those services.

Privacy Statement

SBHP complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have received the SBHP Notice of Privacy Practices and Client Rights.

Consent For Treatment

By signing this form, I consent to and authorize my provider(s) at SBHP to provide me treatment. I understand that I have the right to discuss all treatments with my provider(s) and I have the right to refuse treatment. All of my information is true and correct to the best of my knowledge.

My Signature Below Indicates That I Understand and Accept the Contents of this Form

Signature	Date

5700 172nd Street NE, Ste. B, Arlington, WA 98223
P: 360-435-3985 F: 360-435-7941

Name	DOB	Date

Mental Health Intake Questionnaire

Problems & Concerns	Comments
☐ Family/Relationship	
☐ Anxiety/Panic	
☐ Depression/Sadness/ Grief	
☐ Trauma	
☐ Anger	
☐ Court Ordered/Related to Court Case	
☐ Other -Please describe	

988 Suicide & Crisis Lifeline

People can call or text **988** or chat **988lifeline.org** for themselves or if they are worried about a loved one who may need crisis support.

988 serves as a universal entry point so that no matter where you live in the United States, you can reach a trained crisis counselor who can help.

988 offers 24/7 access to trained crisis counselors who can help people experiencing mental health-related distress. That could be:

- Thoughts of suicide
- Mental health or substance use crisis, or
- Any other kind of emotion distress

988 SUICIDE & CRISIS LIFELINE

FRONT DESK STAFF USE	
Date received:	
CLINICAL STAFF USE	
Date staffed:	Clinician assigned:
Clinical notes:	

5700 172nd Street NE, Ste. B, Arlington, WA 98223
P: 360-435-3985 F: 360-435-7941