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

Client Name:	DOB:

Who May Share My Information

I give my consent to share the following information:

☒ **Stillaguamish Behavioral Health may disclose insurance claims data related to Substance Use Disorder (SUD) treatment to my health insurance provider**.

You must provide consent for us to bill your medical insurance for SUD services. If you do not consent, you may still receive services but will be responsible for cash payments at the time of service.

Note to receiving provider or entity: 42 CFR part 2 prohibits unauthorized re-disclosure of these records.

Information I Agree to Share

Substance Use Disorder	Mental Health	Medical
☒ **Diagnosis**	☐ Diagnosis	☐ Diagnosis
☐ ASAM Assessment	☐ Assessment/Psychiatric Evaluation	☐ Chart Notes
☐ Assessment Summary	☐ Assessment Summary	☐ Medication Summary
☐ Treatment Recommendations	☐ Treatment Recommendations	☐ Lab Results
☐ Attendance/Participation	☐ Attendance/Participation	☐ Discharge Summary
☐ Toxicology/ Drug Test Results	☐ Compliance/ Status Report	☐ Sexually Transmitted Infection Information
☐ Compliance/Status Reports	☐ Discharge Summary	Encounter Dates (if applicable):
☐ Discharge Summary	☐ Psychotherapy Notes	
☐ Appointment Schedule	☒ **Other: Services Received**	

Purpose Of Disclosure

☐ Assist in Diagnosis and Treatment	☐ Coordination of Care	☐ Emergency Contact Notification
☐ Referral for Treatment	☐Report Progress/Verify Compliance	☐ Transportation Coordination

☒ **Billing and/or Health Care Operations**

Consent Expiration

I understand that I can revoke my consent to share my information at any time. Information shared before I revoke my consent cannot be taken back.

My permission ends: ☐ On this date: ☐ One year from signature date ☐ Upon my death

Signature

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered. I understand that I do not need to sign this form to receive care or services.

Print Name of Person Giving Consent:	
Signature of Person Giving Consent:	Date:
Relationship to Client: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Authorized Representative	

Revocation of Consent	
I revoke my consent to share the above information. My consent cannot be revoked to the extent it has already been acted upon.	
Signature:	Date:
FOR BHP STAFF ONLY: ☐ Consent was verbally revoked and client signature is unobtainable.	
Staff Name:	Date:

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