



Lacey Clinic Phone: 360-799-5782 ~ Fax 360-539-1715 ~ Longview Clinic Phone: 360-799-4556 ~ Fax : 360-846-1722
Website: <http://www.pathwaysmhs.org>

ADULT PERSONAL INFORMATION:

First Name:

Last Name:

Preferred Name:

Gender Identity:

Age:

Cell Phone:

Home Phone:

Date of Birth:

Address:

City:

State:

Zip Code:

Email Address:

Social Security Number:

Current Occupation/Employer:

Referral Source:

Relationship Status:

(Ex. Married, Single, Partnered, etc.)

Where would you like to be seen?

Lacey, WA Clinic
 Longview, WA Clinic
 Wellness Program

Telehealth Clinic
 Telehealth Hawaii
 Telehealth Utah

Emergency Contact:

Relationship with the Emergency Contact:

Emergency Contact Phone/Cell Number:



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MENTAL HEALTH HISTORY:

Have you been in counseling/therapy before?

Do you prefer a male or female provider?

Have you been diagnosed with any of the following condition/s?

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Personality Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Alcohol Use Disorder | <input type="checkbox"/> Autism Spectrum Disorder |
| <input type="checkbox"/> OCD | <input type="checkbox"/> Drug Use Disorder | <input type="checkbox"/> Gender Dysphoria |
| <input type="checkbox"/> Other: | | |

Please list current medications (prescribed and over-the-counter):

Alcohol & Drug History:

Any mental health hospitalization? Yes No
If Yes, Where (City & State) When was it?

Reason/s for seeking counseling or therapy?



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INSURANCE INFORMATION:

ALL APPLICABLE INFORMATION (FOUND ON YOUR CARD) MUST BE COMPLETED

Person financially responsible for account:

Relationship to patient:

Primary Insurance:

Patient's Primary Insurance:

Subscriber/Member ID #:

Group ID #:

Primary Insured Name:

Primary Insured DOB:

Required for TRICARE patients ONLY: [write N/A if you do not have Tricare Insurance]

Sponsor's SSN:

Secondary Insurance (if applicable):

Patient's Primary Insurance:

Subscriber/Member ID #:

Group ID #:

Primary Insured Name:

Primary Insured DOB:

Have you contacted your insurance company to verify your eligibility for Mental Health coverage or Telehealth coverage?

Yes: No: *If not, please do so prior to your first appointment.*

TREATMENT CONSENT, FINANCIAL RESPONSIBILITY, AND RELEASE OF INFORMATION

I agree to be financially responsible for no show, last minute and cancelled appointments in accordance with the Pathways MHS cancellation policy as documented by my signature on the Informed Consent. I authorize insurance/EAP benefits to be paid directly to Pathways Mental Health Services, LLC and that Pathways may release any information to my insurance provider required for processing my claims.

Patient Signature:

Date: