Linda Kellam-Keith, **ARNP**

PSYCHIATRIC SERVICES OF OLYMPIA, PLLC
1005 Olympia Ave NE, Olympia Wa, 98506
Telephone: (360)709-3332, Fax: (360)709-3336

PATIENT AND BILLING INFORMATION

Today's Date: _____

Name: _____ DOB: _____

Gender: _____ Male _____ Female Social Security#: _____ - _____ - _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Contact Numbers (Check Preferred): Ok to call & leave detailed messages?

_____ Home: (_____) _____ - _____Yes / No

_____ Cell: (_____) _____ - _____Yes / No

_____ Work: (_____) _____ - _____Yes / No

_____ Email: _____ Yes / No

Preferred Pharmacy Name, Address & Phone Nbr:

_____

Martial Status:

____ Single ____ Married ____ Widowed ____ Separated ____ Divorced ____ Domestic Partner

Occupation: _____

Employer: _____

Who referred you to this practice? _____

Primary Care Provider? _____ Phone: _____

Other healthcare professionals involved in your care (therapists, neurologists, etc.):

_____ Phone: _____

_____ Phone: _____

Emergency Contact: _____ Phone: _____

Address: _____ Relationship: _____

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Primary Insurance: _____

Subscribers Name: _____ DOB: _____

Identification#: _____ Group#: _____

Patient's relationship to subscriber: _____

Secondary Insurance (if applicable): _____

Subscriber Name: _____ DOB: _____

Identification#: _____ Group#: _____

Patient's relationship to subscriber: _____

If another person is responsible for charges:

Name: _____ Relationship: _____

Phone: _____

Address: _____

_____

CONSENT FOR TREATMENT, STATEMENT OF FINANCIAL RESPONSIBILITY, AND RELEASE OF INFORMATION FOR PSYCHIATRIC SERVICES OF OLYMPIA

1. I hereby give my consent for psychiatric and psychological consultation and treatment.
2. I agree to be financially responsible for all charges that accrue from consultation and treatment.
3. I have read and understand the Office Policies, including the Privacy Policy, and agree to the terms within.
4. I hereby give permission to communicate with other healthcare providers involved in my care.
5. By signing below, I also authorize Psychiatric Services of Olympia to release any information necessary to expedite insurance claims.

_____

Patient Signature Date: