COLUMBIA RIVER COUNSELING, LLC

Tacy L. Muzzy, MS, LMHC
1030 N. Center Parkway, Suite 101
Kennewick, WA 99336
509-735-5088

## Demographics/Payment Information

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 ◯ Other Social Security #:____-____-____

Cell/Phone:_____ May we leave a message on this number? ◯ Yes ◯ No

Marital Status:_____ E-Mail Address:_____

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

Emergency Contact:_____ Phone #:_____Relationship:_____

Essential information must be filled out in order to have services with us.
Credit/Debit Card # to keep on file:_____ Exp. Date:__/____ CVC:_____

Name on above card:_____ Zip Code Associated with 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 Holder's Full Name:_____ ◯ Male ◯ Female ◯ Other

Policy Holder's Date of Birth:____/____/____ Relationship to Client:_____

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

**Release of Information:**
Your therapist is not allowed to release information to anyone but you, the client. If you would like our office to be able to discuss anything with anyone besides yourself, please indicate this below:

◯ Only myself
◯ Other (name):_____ What can be disclosed: _____ 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)