P: 509-559-3160 F:509-328-7582
E: admissions@excelsiorwellness.org
3754 W Indian Trail Rd, Spokane, WA 99208

Excelsior – Family Care Spokane (West)
Application for Services

DIRECTIONS:

- Email, Fax, or Mail this completed application ATTN: Admissions Coordinator.
- IF client is over 13, and is being referred by parent or other, an Authorization to Release Information Form must accompany this application.

Requested Services

☐ Psychiatric Nurse Services	☐ Behavioral Health Services	☐ Medical Services
• Psychiatric Evaluations • Psychiatric Prescriptions • Medication Management	• Individual Counseling	• Wellness Checks • Health Screenings • Preventative Care

Client Information

Last Name	First	Middle	☐ Male ☐ Female
Date or Birth	Age	Social Security Number	

Address	Apt #	City	State	Zip

Contact Number	☐ Self ☐ Parent/Guardian ☐ Other: ______	Can we leave a voice message about your care? ☐ Yes ☐ No
		Email Address

Parent/Guardian (PRIMARY) Information

Last Name	First Name	MI	DOB
Relationship to Client	Physical Custody? ☐ Yes ☐ No	Legal Custody? ☐ Yes ☐ No	Emergency Contact? ☐ Yes ☐ No

Address	Apt #	City	State	Zip

Best Contact Number	☐ Cell ☐ Home ☐ Work ☐ Other? ______	Can we leave a voicemail? ☐ Yes ☐ No	Best Time to Call?
Alternate Contact Number	☐ Cell ☐ Home ☐ Work ☐ Other? ______	Can we leave a voicemail? ☐ Yes ☐ No	Best Time to Call?
Email Address:			

Client Medical Insurance

Primary Insurance			Secondary Insurance		
Insurance Company Name			Insurance Company Name		
Policy Holder Name	Policy Holder DOB		Policy Holder Name	Policy Holder DOB	
Policy Holder SSN	Relationship to Patient		Policy Holder SSN	Relationship to Patient	
Group Name	Group No.	Identification No.	Group Name	Group No.	Identification No.
Policy Holder Address		Policy Holder Phone:	Policy Holder Address		Policy Holder Phone:

Client Referral Information

Reason for referral: Chief complaint and symptoms (please be very specific including issues at home, work, or school as well as any symptoms noticed such as mood changes, etc.)

What are your specific goals with treatment services?

Client Medical Information

Are you currently under the care of another provider? ☐ Yes ☐ No

If Yes: Name and Address of current provider(s) your medical hi

Fill out attached Authorization to Release Information Form with the name of your provider allowing us to request your medication history.

Please list all prescription and/or over-the-counter medications currently being taken and the reasons for each

(include prescriber name and phone number):

Medication	Dosage	Reason	Prescriber and Contact Phone Number

Use an inhaler or epinephrine pen? ☐ Yes ☐ No

Please list name/type of inhaler/pen:

Describe any pertinent medical/physical information that might inhibit physical activity

Any dietary restrictions? ☐ Yes ☐ No

If yes, please describe (include any non-allergy related dietary requests/preferences):

Allergies/asthma: List all known allergies to medicines, food, insect bites/stings, etc.

Please include the severity of the reaction, how it was controlled and details/date of last reaction:

Client is aware and in agreement with this referral for services. ☐ Yes ☐ No

Application completed by: ______________________________

Relationship to Client: ______________________________

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AUTHORIZATION FOR THE RELEASE OF INFORMATION

Printed Name of Service Participant: ________________________ Birthdate: ____________

EXCELSIOR	**Entity or Individual** (One Per Sheet)	**Check one choice below:**
3754 W Indian Trail Rd Spokane, WA 99208 Phone: 509-559-3100 Fax: 509-328-7582	____________________ Address: ____________________ City: ____________________ State: __________ Zip: __________ Phone: ____________________ Fax: ____________________	☐ Mutual Disclosure between the Entity/Individual and Excelsior ☐ Excelsior may disclose to Entity/Individual listed ☐ Entity/Individual may disclose to Excelsior

The purpose or need for the exchange and disclosure of this information is to: (BE SPECIFIC check all that apply.)

☐ Facilitate Treatment	☐ Coordinate Continuing Care	☐ Other (please specify)
☐ Summarize Treatment	☐ Legal	____________________

Information to be disclosed: Choose from one of the following columns.

Choice A - All Information		Choice B - Specific Information
☐ I authorize the disclosure of **ALL** information. Information to **EXCLUDE:** Be specific: ____________________ ____________________	**OR**	☐ I authorize only the following information to be released ☐ Identity ☐ Physical Health Records ☐ Dates of Service ☐ Psychiatric Orders ☐ Assessment/Diagnosis ☐ Substance Use Treatment ☐ Discharge Summary ☐ Transition Report ☐ Medical Orders ☐ Treatment Plan ☐ Mental Health Records ☐ Urinalysis/Breathalyzer Results

I understand that my records are protected under federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2 and the Health Insurance Portability Act of 1996 (HIPAA), 45 CFR pts 160 and 164. This Disclosure Authorization is specifically intended to include any references to diagnosis, testing, and/or treatments for communicable diseases, including sexually transmitted diseases (e.g., Tuberculosis, HIV/AIDS), mental health services, drug and/or alcohol services. I understand that my records cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may revoke this consent at any time unless action has been taken in reliance on it. I understand that information used or disclosed under this authorization has the potential of being re-disclosed by another party and thereby no longer protected. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain enrollment, treatment, or payment unless otherwise required or indicated in the provision of quality care. This authorization expires on:__________ (If no date or event is identified, the authorization will terminate 60 days after the last treatment or evaluation session I attend.)

SIGNATURE:________________________ **DATE:** ____________

Note: Minors Ages 13-17 Must Sign: *A minor's signature is required in order to release the following information: (1) conditions related to the minor's reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization and sexually transmitted disease (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older)*

Legal Guardian's signature (for 12 and younger): ________________________

Print Name: ____________________Relationship: ____________DATE: __________

OFFICE USE

Accepted By: ________________________ Date: ____________
[Print Excelsior Staff Name]