Patient Information

Name:_____Address:_____

City/Town:_____ Zip Code:_____

Date of Birth:_____ Social Security Number:_____

Home Phone:_____Msg. ok?___Cell Phone:_____Msg. ok?_____

Email:_____

Emergency Contact:_____

Responsible Party ___ Same as Patient

Name_____Address:_____

City/Town_____ Zip Code:_____

Date of Birth:_____ Social Security Number:_____

Home Phone:_____Msg. ok?___Cell Phone:_____Msg. ok?_____

RECEIPT FOR NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have been provided today with a copy of the attached Notice of Privacy Practices and or have been directed to the website www.breakingthechain.info for Breaking The Chain Counseling, LLC and have been given the opportunity to request restrictions on certain uses and disclosures of my Protected Health Information, and the opportunity to request an alternative method and/or location of communication.

Dated: _____/_____/_____

_____

PATIENT'S OR REPRESENTATIVE'S NAME

Insurance Coverage Information

Breaking the Chain will submit receipts directly to your insurance company if you wish as a courtesy upon receipt of payment for session.

Health Plan Name:_____ Member ID:_____

Group Number:_____Claims Address:_____

Member Services Phone:_____

I authorize Breaking The Chain Counseling, LLC to provide my health plan stated above with a diagnosis and procedure code as well as dates of service. _____

_____ I do not wish Breaking The Chain to submit receipts on my behalf.

Please indicate if the covered person is different from the responsible party on page 1 and fill in the following information:

Name:_____Address:_____

City/Town:_____ Zip Code:_____

Date of Birth:_____ Social Security Number:_____

Payment and Cancelled Session Policy

Payment is due at time of service, cancellation without 24 hours notice will be billed at session rate.

I authorize Breaking The Chain Counseling, LLC to charge my credit card indicated below in the amount of _____ per session and the amount of _____for a session cancelled without 24 hour prior notice.

Name and signature of client:_____

Name and signature of person responsible for payment (if different from

above):_____Date:_____

Credit Card Information (Visa/Mastercard only)

Account Number:_____Expiration:_____

CV code:_____ Billing zip code_____

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

FOR THE PURPOSES OF TREATMENT AND HEALTH CARE OPERATIONS

I, hereby consent to the disclosure by Breaking The Chain Counseling, LLC, of protected health information [PHI] as follows (initial each statement to confirm your consent):

For the purpose of treatment related to clinical issues addressed here by clinical social work services:

_____ 1) to any health care professional who is providing him/her with concurrent care who requests such information to aid in that health care professional's assessment, diagnosis and treatment of him/her;

_____ 2) to any health care professional to whom Breaking The Chain Counseling, LLC may refer him/her so that the referral can be made properly and the care they provide to him/her can be coordinated properly;

_____ 3) to any mental health professional who is providing him/her with concurrent mental health services so that those services can be coordinated properly with the services being provided by Breaking The Chain Counseling, LLC;

_____ 4) to any physician or nurse practitioner who is providing him/her with concurrent medical services so that those services can be coordinated properly with the services being provided by Breaking The Chain Counseling, LLC.

_____ 5) to:_____ Relationship_____

Reason for Disclosure:_____

For the purpose of health care operations of: Breaking The Chain Counseling, LLC:

_____ 1) to the business associates of Breaking The Chain Counseling, LLC provided that there is a business associate agreement in place between Breaking The Chain Counseling, LLC and the business associate which requires the business associate to safeguard the privacy, confidentiality and security of the PHI which is disclosed to them.

This consent will be valid until Breaking The Chain Counseling, LLC ceases providing clinical social work services to me (or the person for whom I am signing this consent) or until Breaking The Chain Counseling, LLC receives from me written revocation of all or part of this consent. My revocation of this consent will not apply to any action Breaking The Chain Counseling, LLC has taken in reliance on this consent prior to receiving my written revocation of all or part of this consent.

Also, to the extent that this consent permits the disclosure of PHI for the purposes of payment, this consent will be valid for the disclosure of any PHI related to services Breaking The Chain Counseling, LLC rendered until the time Breaking The Chain Counseling, LLC received my written revocation of consent, even if such disclosure is made after my written revocation. In other words, my written revocation will not apply to disclosures made after the date Breaking The Chain Counseling, LLC prior to my receipt of my written revocation.

Dated: _____/_____/_____ Signature of Patient or Responsible Party_____