

CONSENT FORM

Client Name: _____

Release/Exchange

I consent to the release of information from Processes, P.A. to my insurance company, EAP, and/or managed care group to facilitate payment and continued coverage under the mental health benefit of my policy.

Assignment of Benefits

I consent to have Processus, P.A. submit claims on my behalf to my insurance company, EAP, managed care, or other third party payer and receive payment according to the guidelines of my policy.

X _____
Signature of Client or Parent/Guardian Date

Confidentiality Release

 to protect your privacy at home, please note the following:

- It is okay to leave a message at home (i.e. reminder calls)
- DO NOT leave messages at my home
- If you make reminder calls, I prefer you contact me at _____ (work, home, cell)

On my/the client's behalf, ONLY the following individuals can check on appointments and/or discuss billing or insurance information (write name of those individuals you wish to authorize). We will assume "self only" unless otherwise indicated.

Spouse: _____ Supervisor/Boss/Secretary: _____
Parents/Guardians: _____ Other : _____

X _____
Signature of Client or Parent/Guardian Date

Physician Release

(please indicate which option)

- No physician at this time.
- Do not release information to my physician at this time.
- I authorize Processus, P.A. to release or exchange clinical and/or medical information to/with my physician as considered necessary by Processus.

Name of physician: _____ Phone: _____
Address of physician: _____

X _____
Signature of Client or Parent/Guardian Date

Privacy Policy/Billing Policy/NPP

Acknowledgement of 24-hour notice: *(please initial)*

For my records I have received the "Client Rights and Data Privacy Information", the clinic Billing Policy, and I am aware that the Notice of Privacy Practices is available upon request.

X _____
Signature of Client or Parent/Guardian Date