Consent for Services

Patient Name:_____ Phone:_____

Email Address: _____ DOB: _____

Address: _____

ASSIGNMENT OF BENEFITS

By signing below, you are authorizing the release of necessary information about your case to your primary and, if applicable, secondary insurance to process your insurance claim. You are also assigning benefits to Blue Moon Senior Counseling for any eligible payments from your insurance carrier. This is a direct assignment of the rights and benefits under the insurance policy. Your signature below will serve as a signature on file, and may be revoked in writing at any time.

CONSENT TO TREATMENT

I authorize and request that a Blue Moon Senior Counseling clinician, provide psychotherapeutic assessment and treatment which now and/or during the course of my care as a patient are advisable. I understand my therapist may change for various reasons and this consent is for any Blue Moon Clinician to provide treatment. The frequency and type of treatment will be decided between my therapist and me. I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur. I understand maximum benefit will occur with consistent attendance and at times I may feel conflicted, as the process can sometimes be uncomfortable. I agree to the 24 hour notice of cancellation policy. I understand the limits of confidentiality regarding my treatment. Those limits have been described to me as: if I am a danger to myself or others, in child or adult abuse cases and/or if there is a subpoena for records by a court of law. I have read and fully understand this form.

Consent for use and disclosure of Protected Health Information

With my consent, **Blue Moon Senior Counseling** may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to **Blue Moon Senior Counseling's** Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

I understand that **Blue Moon Senior Counseling** reserves the right to revise its Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, (10204 Bode St STE B Plainfield IL 60585).

With my consent, **Blue Moon Senior Counseling** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Blue Moon Senior Counseling** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, **Blue Moon Senior Counseling** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Blue Moon Senior Counseling** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form I am consenting to **Blue Moon Senior Counseling** use and disclosure of my PHI to carry out TPO. At any time, I may revoke my consent in writing, by sending a signed and dated written statement to Privacy Officer (10204 Bode St STE B Plainfield IL 60585) **Blue Moon Senior Counseling**, saying that I am revoking my authorization to disclose health records, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Blue Moon Senior Counseling** may decline to provide treatment to me. I understand this consent will automatically renew in 1 year unless otherwise specified:

_____ _____ _____ _____

BMSC Representative's Signature **Date** **Patient/POA/Guardian Signature** **Date**

_____ _____

Printed Name of Clinician **Printed name of Patient/POA/Guardian**

Patient Authorization for Release of Health Information

Patient Name: _____ Phone#: _____

Email Address: _____ DOB: _____

Address: _____

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) **Blue Moon Senior Counseling** will not release confidential health information, either in person or by telephone, email, or fax to any unauthorized people. When returning telephone calls, we will not leave a message on an answering machine or voicemail unless we are authorized in writing to do so. Information will not be given to an unauthorized person who may answer your telephone. If you would like to authorize us to release medical information to someone other than yourself or to leave information on a recording device, please complete the following:
I authorize the staff of **Blue Moon Senior Counseling** to release confidential medical information pertaining to my care by the following methods and to the following people. I understand that it is my responsibility to notify **Blue Moon Senior Counseling** if this authorization information changes.

It is ok to leave confidential medical information for me on my:

[] Home telephone/message _____ [ ] Mobile telephone _____

It is okay to give confidential medical information to my: (List specific names)

[] Family member(s) _____
[] Facility Staff _____
[] Other (s)_____
[] Other (s)_____

I authorize this information to be disclosed in the following ways:

[ ] Written/photocopy/paper [ ] Verbal [ ] Facsimile

Specific description of the protected health information that I authorize for disclosure:

[ ] Progress notes [ ] Entire health records, (including, but not limited to information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities).
[ ] Treatment Progress, [ ] Other_____

I give specific authorization to disclose the following information:

[ ] Psychiatric/mental health treatment records/information
Indicate/describe each authorized purpose of the use or disclosure:
[] At the request of the individual (patient) [] Other

_____

_____

I understand this authorization will automatically renew in 1 year unless otherwise specified: _____
I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Signature of Clinician	**Date**	**Patient/POA/Guardian Signature**	**Date**
Printed Name of Clinician		**Printed name of Patient/POA/Guardian**	

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