Life Change Psychotherapy Institute, P.C.

Assignment of Benefits:

I authorize and request the direct assignment of insurance or government benefits and payments for such services to Life Change Psychotherapy Institute, PC

___________________________________ _______________________

(Signature of patient or authorized representative) (date)

****

General Consent to Disclose Protected Health Information to Process Insurance Claims, and to Provide Billing Services; and Notice of Patient Rights and Privacy Practices

To process insurance claims and conduct health care operations, a certain amount of Protected Health Information is required from your doctor about your care. This information is routinely used in the processing of claims, for the authorization of current or future services, and for determination of the medical necessity and the level of care reasonably required to treat you appropriately. Governmental oversight committees and agencies also may legally have access to this information to assure your doctor is complying with state and federal law. Many insurance contracts also include clauses that require disclosure of Protected Health Information from specialty providers to your primary-care physician in order to coordinate your care. You have a right to consent to, deny, or request reasonable restrictions to the disclosure of Protected Health Information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Protected Health Information (PHI) includes such information as your name, Social Security number, insurance ID number, billing account number, dates of treatment, procedures performed, the type and frequency of treatment, costs of treatment, your symptoms, history of symptoms, medical history, clinical lab tests, medications, current functional status, diagnosis, prognosis, and the treatment plan. Your insurance company has a legal responsibility to treat this information as confidential and safeguard its care and use. Criminal and civil penalties may be applied for misuse or wrongful disclosure of your Protected Health Information. If you choose to deny or restrict release of this information, your insurance company may refuse to pay for services or refuse to authorize payment of future services. <u>Consenting to the release of Protected Health Information does not permit the release of Psychotherapy Notes to your insurance company or any other party</u>. Psychotherapy Notes, as defined by HIPAA, have additional protections and rules applied to them and are considered restricted at a level above and beyond Protected Health Information. The federal law requires you to provide specific authorization for the disclosure of Psychotherapy Notes in a separate authorization. The federal law specifically states that insurance companies, managed care companies, and ERISA certified plans may not require patients to authorize release of Psychotherapy Notes as a condition of insurance coverage or payment for services. You have a right to receive an accounting of how Protected Health Information was used, shared, or disclosed from your provider or from the insurance company, HMO, or third party payer that disclosed or shared it. You have a right to access your records for inspection of Protected Health Information and submit a written amendment to be placed in your billing, medical, or psychotherapy record if you request it. You have a right to revoke your consent for the release of Protected Health Information at any time with a written statement that is signed and dated. However, information that has already been released related to your prior consent cannot be rescinded or revoked. Please read and sign the authorization below to consent to the release of Protected Health Information to your insurance carrier, HMO, or third-party payer of services and to permit billing, transcription, and the conduct of health care operations.

I hereby consent to disclosure of Protected Health Information by Life-Change Therapy Institute to insurance carriers, billing agencies, subcontractors, and electronic clearinghouses as required to process insurance claims, to authorize services, to pay for services, to comply with federal and state law, and to conduct health care operations. My signature below indicates that I have been fully apprised of my rights and I have received and read a copy of The Notice of Privacy Practices given to me.

____ __________________________

(Patient signature) (Date)

____ __________________________

(Legal guardian or representative) (Date)

(HIPAA compliant form adopted 6/15/2003)

1200 Eubank Boulevard NE
Albuquerque NM 87112
505-271-5050 office
505-271-1080 fax
www.lifechangetherapy.net
staff@lifechangetherapy.net