Mary E Joyce, LPC, CADC I

Consent to Release Confidential Information for Insurance Purposes

Name: _____

Date of Birth: _____Social Security Number:_____

- ☐ I authorize release of restricted information related to my mental health services sufficient to assure payment for services by insurance carrier.
- ☐ I authorize release of payment insurance benefits to the office of Mary E Joyce, LPC, CADC I for services rendered to me or my dependents while a client at the above named office.

I understand that, by law, I am not required to consent to this release. This consent is not required for my treatment; however, I choose to do so willingly for the purposes specified above. I understand that I may revoke this consent, in writing, at any time, except to the extent that the action has been taken in reliance of my consent. I understand that copies of all my billings and reports released to my insurance company or its agents are available to me upon request.

Definitions:

Treatment includes activities performed by this practice in providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care professionals.

Payment includes uses and disclosures required for determining your eligibility for health plan coverage, billing and receiving payments for your health benefit claims, and health plan management activities which may include review of your services for clinical necessity, justification of charges, precertification and preauthorization.

Changes in Privacy Practices: We reserve the right to change privacy practices to remain in compliance to HIPAA Privacy Rules. You will receive a blue copy of *Notice of Privacy Practices* at your intake appointment. As part of the *Notice of Privacy Practices* you have the right to restriction of how we use and disclose your protected health information for treatment and payment purposes. We are required to agree to your request unless the information is needed to provide emergency treatment to you.

Signature: _____Date: _____

Client or Parent or Legal Guardian of client

I have received the BLUE copy of Notice of Privacy Practices: Initial: _____