CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Client Name:___________________________________

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as “healthcare operations”). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. You may ask for a printed copy of my Notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or healthcare operations: however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

If you choose to pay out-of-pocket for services instead of utilizing your health insurance, you have the right to restrict the release of healthcare information to your health insurance provider.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my protected Health Information as specified above.

__________________________________________  __________________________
Signature of Client/Guardian                      Date

__________________________________________  __________________________
Signature of Therapist/Witness                    Date

I request the following restrictions on use and disclosure of my healthcare information:

____________________________________________________________________________________
____________________________________________________________________________________

__________________________________________  __________________________
Signature of Client/Guardian                      Date

__________________________________________  __________________________
Signature of Therapist                           Date
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received a copy of this office’s Notice of Privacy Practices.

______________________________________________
Print Client Name                                Client Date of Birth

______________________________________________
Client/Guardian Signature                        Date

I agree to be contacted in the following manner (check all that apply):

☐ Cell phone: (_____) __________________________
  ☐ Detailed message ok
  ☐ Text message ok
  ☐ Name and call back number only

☐ Work phone: (_____) __________________________
  ☐ Detailed message ok
  ☐ Name and call back number only

☐ Home phone: (_____) __________________________
  ☐ Detailed message ok
  ☐ Name and call back number only

☐ Email: _________________________________

☐ Other: _________________________________

☐ Mail to home

☐ I wish to receive appointment reminders by ___ email and/or ___ text message. (check one or both)
☐ I do not wish to receive appointment reminders.

______________________________________________
Signature                                            Date

For Office Use Only

Unable to obtain signature due to the following reason:
  ☐ Refused to sign
  ☐ Communications barriers prohibited obtaining signature
  ☐ An emergency situation prevented us from obtaining signature
  ☐ Other (specify) ________________________________