Deborah Carnett, M.Ed, M.S., LMHC

Client Insurance Information & Other Provisions

Please print and fill out completely:

Client Name: _____ Date of Birth:_____SSN: _____

Address: _____City/State:_____Zip:_____

Home phone: ___(_____)_____ Cell/Work phone: ___(_____)_____

INSURANCE COVERAGE:

Insurance Company Name: _____ Phone No:____(_____)_____

Billing Address: _____City/State:_____Zip:_____

Subscriber Name: _____ DOB: _____

Subscriber ID# :_____Group #: _____ SSN: _____

Subscribers Address: _____City/State:_____Zip: _____

Subscriber's Employer: _____Subscriber's Work #: __(_____)_____

SECONDARY INSURANCE:

Insurance Company Name: _____ Phone No:__(_____)_____

Billing Address: _____ City/State: _____Zip:_____

Subscriber Name: _____ DOB: _____

Subscriber's ID#:_____ Group #: _____ SSN:_____

Please identify the Person Responsible for Payment of account:

Name: _____ DOB: _____SSN:_____

Address: _____City/State: _____Zip: _____

Responsible Party Employer: _____

Your relationship to person responsible for payment: (Please circle one): Self Spouse Child Parent

Release of Information Authorization to Third Party

I (we) authorize Deborah Carnett, M.Ed, M.S., LMHC to disclose case records (diagnosis, case notes, psychological reports, testing results, and other requested materials) to the above listed third party payer or insurance company for the purpose of receiving payment reimbursement directly to Deborah Carnett, M.Ed, M.S., LMHC.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice and after one year this consent expires. I (we) have been informed of what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to these conditions and have received a copy of this form.

I (we) understand that this authorization is not a guarantee of payment from my insurance company and that I (we) are ultimately responsible for payment of my account in a timely manner. If, for any reason, my insurance requires any completion of phases in treatment I (we) understand that it is the policy of Deborah Carnett, M.Ed, M.S., LMHC that I must pay for treatment and can, at a later date, apply to my insurance company for reimbursement.

_____/_____ _____

Signature(s) of Person(s) Responsible for Payment Date

_____/_____ _____

Signature(s) of Person(s) or Guardian(s) Date

Other Provisions

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnoses, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and – the client's credit report may state the amount owed, time frame and name of agency.

Clients who have accounts that are 30 days past due, or owe more than $50.00, will need to pay their bill in full before scheduling further appointments.

Insurance companies and other third party payers are given information that they request regarding services to clients. Information they may request includes type of services, date/times of services, diagnosis, treatment plan and description of impairment, progress, case notes, and summaries. Insurance claims are filed through a billing service I contract with. My biller has signed a confidentiality clause and every effort is made to ensure that private client information is kept confidential. If you have any concerns about this, please bring them up to me.

When couples or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. This information includes (a) testing results, (b) information given to me not in the presence of the other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information requested to be separate. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in other's presence, is kept in each file as case notes.

In the event that I must telephone you for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list below where I may reach you by phone and how you would like me to identify myself. For example, you might request that when I phone you at home or work, I do not say the reason for my call, but rather give my first name only.

If this information is not provided to me (below), I will adhere to the following procedure when making phone calls. First, I will ask to speak to you or (guardian) without identifying myself. If the person answering the phone asks for more identifying information I will say that it is a personal call. I will not identify the nature of the call in order to protect confidentiality. If I reach an answering machine or voice mail, I will follow the same guidelines.

PLEASE CHECK BELOW THE PLACES WHERE YOU CAN BE REACHED BY PHONE:

____Cell or Home _____ _____
Phone # How should I identify myself?

____Work _____ _____
Phone # How should I identify myself?

********** *I agree to the above limits of confidentiality as stated in "Other Provisions" and understand their meaning and ramifications. I've asked questions about anything that is not clear to me and had my questions answered to my satisfaction. I have been offered a copy of this document.* **********

_____ _____ _____
Client's Name (please print) Client's (or Guardian's) Signature Date

(Effective 10-13)