AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

• 638 Lake Street, P.O. Box 818, Wilson, NY 14172 • Phone: (716) 379-3557

I, _____, hereby authorize, **Annie Coburn-Kane, LCSWR,**
(Name of client/guardian)
to release to and to receive from:

_____

_____

the following information about:_____

INFORMATION TO BE RELEASED

_____ 1. Copies of chart notes.

_____ 2. Copies of entire record, i.e., chart notes, billing information, reports prepared by therapist, etc. (not necessarily including therapist's personal notes).

_____ 3. Summary of impressions, diagnosis, treatment, response to treatment, history, recommendations, psychological test results. (may include copies of reports prepared by therapist).

_____ 4. Copies of computer-generated test reports.

_____ 5. Other (specify) _____

PURPOSE OF DISCLOSURE

This authorization allows your mental health provider to send/receive the above information to/from the above-named parties. (In addition, a thank you letter to the referring agency or individual is sometimes sent.) The specific purpose(s) of this disclosure (is/are):

_____ 1. To coordinate with other health/mental health providers

_____ 2. To obtain insurance or employment or government benefits.

_____ 3. To coordinate with attorneys, judges, probation officers, etc.

_____ 5. To coordinate with school officials/teachers, etc.

_____ 6. To obtain/provide history.

_____ 7. Other _____

I understand that my records are protected under the Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed without my written consent. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below.

EXPIRATION DATE: _____

Signature of Client or Parent/Guardian _____ Date: _____
(indicate relationship to client)

Signature of Witness: _____ Date: _____

Annie Coburn-Kane, LCSW-R

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•www.wellnesswilson.com •

Billing Policy

Please be aware that co-payments, co-insurances, etcetera are due at the time of service. A $5 (five dollar) billing fee will be added to your account if the time of service requirement is not met. If your insurance policy includes a deductible, you must pay the entire allowable fee at the time of service as well. The above billing fee applies if this requirement is not met. If your insurance company notifies us that your deductible has been met, your account will be credited the appropriate amount. If we are certain that your deductible has been met at the time of service, the appropriate co-payment or co-insurance applies.

All co-payments for services provided to a child are the responsibility of the person bringing the child to the visit, even if you have a separation or divorce agreement that states otherwise. It is up to you to work out financial responsibility with the other parent.

Please note that an additional fee will be added each month that the balance remains outstanding. For example, after two months the billing fee will be $10.00 (ten dollars). Also, if co-pays and/or deductibles are not made at the time of service, additional visits may not be scheduled and/or future appointments may be office cancelled.

Please be aware that if, at any time, there is a change of insurance, our billing office must be notified of the new insurance information at least 3 days prior to your next scheduled appointment. If new insurance information is received at the time of your appointment, the appointment will be considered self-pay until the insurance is verified by our billing office. Not all therapists participate with every insurance plan and some plans require pre-authorization in order for the insurance company to reimburse for services provided.

If you have any further questions, please feel free to contact the office at (716) 379-3557.

_____ _____

(Patient/Parent Signature) (Date)

_____

(Print Name)

Annie Coburn-Kane, LCSW-R

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Consent for Treatment & Performance of Health Care Operations

I, _____, hereby authorize, Annie Coburn-Kane, LCSW-R to provide treatment. I also authorize Annie Coburn Kane, LCSW-R and her business associates (Wilson Wellness) to carry out healthcare operations relating to that treatment, including:

- Verifying, authorizing, & billing 3rd party insurances
- Sending any self-pay bills to your address
- Carrying out operations that are necessary to maintain schedules and charting
- Contacting insurance companies and primary care physicians to obtain referrals
- Allowing your insurance company to review your chart for the purpose of funding treatment
- Other: _____

I acknowledge that I have received, and understand the information contained in the following:

- Patient Orientation Handbook
- Notice of Privacy Practices (NPP)/ HIPAA Form
- Consent for Treatment & Healthcare Operations (this form)
- Patient Information Sheet
- Billing Policy
- Missed Appointment Policy
- Courtesy Call Consent Form
- Release of Information Form
- Electronic Communication Consent Form

My signature below indicates:

I have been informed of my rights and responsibilities as a patient, including my right to the maintenance of confidentiality. The risks and benefits associated with treatment have also been explained to me. I have had the opportunity to have all my questions answered fully.

I understand that my records are protected under the Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed to third parties without my written consent. I understand that my confidentiality privilege can be waived in the event of a court order, suspected child abuse or neglect, statements indicating that you may harm yourself and/or another person, or a medical emergency.

I am also aware that my insurance company and/or other third party payor(s) may request additional information in order to process my claim and/or authorize continuing services. Information requested may include, but not be limited to, presenting complaint, current symptoms, treatment plan, and progress in treatment. I understand that I have the right to self-pay, the right to review my treatment record, and the right to have any inaccuracies corrected in the record.

I agree to pay for this treatment. I understand the billing process, and the fee schedule. I understand that I must call to cancel an appointment at least 24 hours in advance, or a fee may be incurred. I understand that failure to pay for costs for which I am liable may ultimately result in my account being forwarded to collection.

I understand that I may revoke this consent (terminate treatment) at any time. My signature acknowledges that I have read and understand the Consent to Treatment form and agree with it. I also recognize that I'm entitled to a copy of this form should I request it.

Signature of Client/Guardian: _____ Date: _____

Annie Coburn-Kane, LCSW-R

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Courtesy Calls

Wilson Wellness has implemented an automated courtesy call system. The information being disclosed will be the clinician's name, as well as the date and time of the appointment. If you are interested in receiving a courtesy call, please fill out the information below and return this form to the receptionist.

Please note that only one phone number can be listed for these calls. Therefore, if the patient is a child, we can only provide a courtesy call to one parent.

Patient's Name: _____

Would you like to receive a courtesy call prior to you appointment? ☐ Yes ☐ No

Phone number you would like is to call: (_____) _____ - _____

These reminders act as a courtesy, therefore it is your responsibility to make, keep, and cancel appointments, or to notify us if your contact information should change.

By signing this form you are releasing us from any liability associated with leaving information regarding your (or your child's) appointment.

_____ _____

(Patient/Parent Signature) (Date)

_____

(Print Name)

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Acknowledgement and Consent to Use Electronic Communication

I have been advised and understand that the use of email, cell phone texting, and other forms of technology in psychotherapy has not been defined as a best-practice strategy. I have also been specifically advised of the following:

1. Email/texting communication with Annie Coburn-Kane, LCSWR (Wilson Wellness) will be used for the purpose of simplifying and expediting scheduling/administrative matters only.
2. Email/texting communication is NOT to be used to provide/receive treatment services or take the place of therapy sessions. Therefore, email/texting should ***NOT*** be used to communicate:
    - Suicidal or homicidal thoughts or plans
    - Urgent or emergency issues
    - Serious or severe side effects or concerns
    - Rapidly worsening symptoms
3. In a life-threatening emergency, clients should:
    - Call 911
    - Proceed to the nearest hospital emergency room
    - And/or call Crisis Services 716-285-3515
4. Any information exchanged electronically or with the use of technology increases the risk of confidentiality breaches. No technology is 100% secure and the therapist cannot guarantee protection from unauthorized attempts to access, use, or disclose personal information exchanged electronically.
5. The use of email, cell phone, or other forms of technology does not change the fact that the service provided by Annie Coburn-Kane, LCSWR (Wilson Wellness) are 45- 60-minute psychotherapy sessions scheduled and confirmed by both parties in advance of the sessions. Annie Coburn-Kane, LCSWR (Wilson Wellness) does not provide crisis intervention, and email/cell phone texting is not a reliable way of obtaining urgent help from the therapist in an emergency.

I have thoroughly considered all of the above information, and I have obtained whatever additional input and/or professional advice I deem necessary in making an informed decision regarding email/texting communication.

By signing, I consent to the use of email/cell phone texting as needed for scheduling and administrative purposes only, within the guidelines above. If more urgent help is needed, I will utilize the crisis services listed above in Line 3. Furthermore, if at any time my therapist or I believe email/texting is interfering in my therapeutic process or being used ineffectively, either of us can revoke this consent verbally, refuse to respond to emails/texts, and insist upon a verbal conversation before proceeding.

Client/Guardian Signature _____Date _____

Therapist Signature _____ Date _____