Patient Name _____ Date of Birth _____

COUNSELING CLINIC, LTD.
RUTH COHEN KUBICEK, LCSW, CADC, RYT

PLEASE READ AND INITIAL EACH SECTION:

CONSENT FOR RELEASE OF INFORMATION TO INSURANCE PLAN AND ASSIGNMENT OF BENEFITS:

_____I give consent to Counseling Clinic, Ltd., Ruth Cohen Kubicek, LCSW, CADC, RYT to release medical information to my insurance carrier(s), managed care company(ies), Employee Assistance Programs(s) or their representatives concerning my illness and treatments. I certify that the information I have reported with regard to my insurance coverage is correct. I give consent for the release of any necessary medical information for this or any related claims, in writing (i.e., treatment plans) or verbally (i.e., requesting benefit/authorization information by phone) or electronically (i.e., requesting benefit/authorization information electronically). I permit a copy of this consent to be used in place of the original. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided. It is customary to pay for services when rendered unless other arrangements have been made in advance with a member of management. If any insurance company limits visits, I accept responsibility for monitoring the number of allowed sessions used. I agree to pay for all non-covered services including late cancellations/missed appointments, services provided after benefit exhaustion, and services determined not to be necessary by my insurance carrier. I permit a copy of this consent to be used in place of the original.

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION FOR TREATMENT

_____I consent to treatment by Counseling Clinic, Ltd., Ruth Cohen Kubicek, LCSW, CADC, RYT. I permit a copy of this consent to be used in place of the original.

_____I give consent to Counseling Clinic, Ltd., Ruth Cohen Kubicek, LCSW, CADC, RYT to share necessary health information with staff they may hire to assist with billing, scheduling, or other office operations. I permit a copy of this consent to be used in place of the original.

CONSENT FOR RELEASE OF INFORMATION FOR APPOINTMENT REMINDERS, TREATMENT ALTERNTIVES/RECOMMENDATIONS, OR HEALTH-RELATED SERVICES

_____I give consent to Counseling Clinic, Ltd., Ruth Cohen Kubicek, LCSW, CADC, RYT to contact me verbally by phone or electronically by phone for appointment reminders, treatment alternatives/recommendations, or healthcare-related services. I permit a copy of this consent to be used in place of the original.

POLICY FOR RELEASE OF INFORMATION IN SPECIAL SITUATIONS:

_____I understand that Counseling Clinic, Ltd., Ruth Cohen Kubicek, LCSW, CADC, RYT may disclose health information about me in the event of a serious threat to the health and safety of myself or others, in the event of suspected child abuse or neglect, or in other situations as detailed in the Notice of Privacy Practices. I permit a copy of this policy acknowledgement to be used in place of the original.

POLICY REGARDING LATE CANCELLATIONS/MISSED APPOINTMENTS:

_____I understand and accept that if I miss a scheduled appointment or if I cancel an appointment with less than 24 hours notice (message may be left on voicemail 24 hours a day/7 days a week), I am responsible for the missed appointment fee for that appointment. I understand that insurance companies do not pay fees for missed appointments or late cancellations; I understand that this policy applies to illness, injuries, work problems, childcare problems, and other last-minute obligations. The only exception is a regional weather emergency. I permit a copy of the policy acknowledgement to use in place of the original.

POLICY FOR EMERGENCY CONTACT:

_____I understand that if I have a mental health emergency, I should contact my provider at Counseling Clinic, Ltd., Ruth Cohen Kubicek, LCSW, CADC, and RYT but if I am unable to reach my provider, I should call 911 or go to the nearest emergency room.

_____ _____
Signature of Patient or Legal Guardian Date

Effective 01/03/2014