CsC CounselSmith Cottage - Pamela Smith McSpadden, MA, LPC
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www.counselingcottage.com

INSURANCE AUTHORIZATION AND ASSIGNMENT (please, read and sign)
I hereby authorize the provider to release any information acquired in the course of my examination or treatment to my insurance carrier, and I hereby assign to the provider all payments for medical services rendered to myself. I understand that I am responsible for the payment of services. Insurance will be filed as a courtesy; however, after 60 days if no response is received, I understand that I will be responsible for any charges. I understand that I am responsible for payment of any amount that is not covered by insurance.

Assignment of Insurance Benefits:
The undersigned hereby authorizes the insurance carrier, or any Insurance carrier represented as contractually responsible for payment in whole or part of the patients healthcare bill, to pay directly to the provider responsible for my care, benefits payable to me.

I agree that, should the amount be insufficient to cover the provider's charges, I will be responsible for payment of the difference and that if the nature of the disability be such that it is not covered by the policy, I will be responsible for payment of the entire bill, unless contractual agreements have been made between the provider and the insurance company which negate that responsibility.

_____ _____
Signature Date

_____

Consent for Purposes of Treatment, Payment, and Behavioral Healthcare
I consent to the use or disclosure of my protected health information by Pamela Smith McSpadden, MA, LPC for the purpose of diagnosing or providing treatment to me and obtaining payment for my healthcare bills. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed for treatment, payment or healthcare operations of the practice. Pamela Smith McSpadden, MA, LPC is required to agree to the restrictions that I may request. However, if Pamela Smith McSpadden, MA, LPC agrees to a restriction that I request, the restriction is binding by Pamela Smith McSpadden, MA, LPC.

I have the right to revoke this consent, in writing, at any time, except to the extent that Pamela Smith McSpadden, MA, LPC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my provider, another healthcare provider, a health plan, my employer, or healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

NOTICE TO CLIENTS: Information in your records that you have or may have a communicable disease made confidential by law and cannot be released without your permission except in limited circumstances including releasing to person who have had risk exposures, release pursuant to an order of the court, or the Department of Health, release health care providers or for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you can be identified unless release of that identifying information is authorized by you, by order of the court or the Department of Health or by law.

Pamela Smith McSpadden, MA, LPC Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performances of healthcare operations of Pamela Smith McSpadden, MA, LPC The Notice of Privacy Practices is posted on the CounselSmith Cottage website and in the waiting area of the office.

Pamela Smith McSpadden, MA, LPC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and requesting a revision be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature Date