

PERMISSION STATUS

My Initials and Signature below indicates the following: (please initial before each section)

_____ **I have received a copy of Limits of Confidentiality.**

--I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ **I authorize permission to receive treatment by the mental health professional.**

_____ **I authorize permission to allow electronic communication between APPS/staff and myself
(email, text, cell phone, internet) and have received a copy of the electronic communication information sheet.**

_____ **I agree to meet my responsibilities below and towards payment for services rendered.**

--I hereby authorize the release of any medical information necessary to process my claims to the insurance company. I hereby authorize payment of medical benefits for services rendered to me and/or my dependents by Mary M. Andersen, RN, CNS, MSN to be paid to Mary M. Andersen, RN, CNS, MSN

--I agree to inform APPS of any changes in insurance company policy or coverage in a timely manner (within 30 days of their scheduled appointment)

--I understand that I am financially responsible to Mary M. Andersen, RN, CNS, MSN for the charges not covered by the assignments of the benefits above.

--I (we) have read, understand, and agree with the provisions of the Financial Policy and "missed appointment or late cancellation fees."

_____ **I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to this clinic**

Patient Signature: _____ Date: _____

Responsible Party: _____ Date: _____

Release Required on all Behavioral Healthcare Providers (BHP) Managed Patients

I understand the confidentiality of my records as protected by law. Information about me cannot be released without my consent. I understand I may revoke this consent at any time, and it will automatically expire without my revocation after one (1) year from the date of signature. I do not authorize release of this information by the recipient unless further release is specifically authorized.

I hereby give authorization for Mary M. Andersen, RN, CNS, MSN to contact and inform BHP Intake of all medical information included in this treatment plan, and

I hereby give authorization for Mary M. Andersen, RN, CNS, MSN to contact and inform my Primary Care Physician of all medical information included in this treatment plan; and

I hereby give authorization for BHP Intake to contact and inform my Primary Care Physician of all medical information included in this treatment plan.

Patient Signature/Date Signed: _____ Date _____

Responsible Party Signature/Date _____ Date _____