BEYOND THERAPY

337 Harvey Ave Greensburg, PA 15601-1994
724-832-7157 Fax: 724-832-1821

CONFIDENTIAL: PROTECTED HEALTH INFORMATION- Authorized Personal Only

Evaluation (first appointment) Date: ____________________

Client Name: ___________________________________ Your Date of Birth: _________________

Address: ____________________________ City, State, Zip: __________________________________

(H) Phone: ______________ (W) Phone: ________________ Cellular Phone: _____________________

May we contact you at home? Yes no May we call you at work? Yes no

Your Social Security# ____________________ (must have this for all client including children)

Your Employer Name/Address ____

Marital Status: Single Married Divorced Separated Widowed

Spouses Name: ____________________________ Employer ______________________________________

Parents Names (if client under 18 Years): ____

Address (if different than yours): ____

Current Insurance: Insurance ___________________________________Co-payment: _________________

Insurance ID # : ____ Group#:_______________________

Deductible Amount ? __________________________ Has your yearly deductible been met? _______________

Primary Insurance Member Name: ___________________________________ Date of Birth: ______________

There complete address :____

There place of Employment _____________________________ Do you have other Insurance? _____________

Medical Information

Current Medication Dosage and times per day Medication start date Doctor Name

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____

I agree to allow Beyond Therapy to bill my Insurance Company for all services I receive at Beyond Therapy. I agree to pay to Beyond Therapy any co payments or deductibles that my insurance company does not cover for my services at Beyond Therapy. I agree to provide to Beyond Therapy my current insurance information and notify Beyond Therapy of any changes to my insurance for Behavioral Health Services. I am responsible for any charges that are not paid for by my insurance company. If I fail to show up for or cancel a scheduled appointment. I will be billed directly the current rate for my services. I have received or been offered a copy of HIPPA.

Printed Name: ____

Signature:___________________________________ Today's Date: _______________________________

Beyond Therapy

Limits of Confidentiality

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PLEASE READ & SIGN

Contents of a therapy, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of my practice not to release any information about a client without a signed release of information. Noted exceptions are as follows____

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child or spouse's records.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

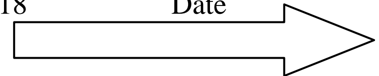
Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, and description of impairment, and progress of therapy.

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

________________________________ ____ _________________

Client's Name (please print) Client's (or Guardian's) Signature if under 18 Date



Beyond Therapy
438 Pellis Road, Suite 202
Greensburg, PA 15601
Phone: 724/832-7157 Fax: 724/832-0401

CLIENT CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Authorized Personnel Only

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary. If I do not sign this form, my doctor may not receive information that is important to my treatment. This disclosure is to coordinate my diagnosis and my treatment. I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire 1 year from the date of signature, unless another date is specified. This release is required by all insurance companies. ***Insurance companies consider all treatment to be medically necessary.***

I, ____________________________________, ____________________, ___________________________, for the
(Patients Name – Print) **(Patients Date of Birth.)** **(Patients Social Security #)**

purpose of coordinating care, authorize Beyond Therapy: ____, to
(Provider Name – Print)
release information indicated in the "Consent" portion of this form to be sent or faxed:

PCP Name: ____

PCP Phone: (_) ___________________________ **PCP Fax:** (_) _______________________________

PCP Address: ____
(Street) (City) (State) (Zip)

Patient please check one:

( ) To release any applicable mental health/substance abuse information to my primary care physician.

( ) I do not give my consent to releasing any information to my primary care physician. (This may affect insurance approval benefits for additional session requests)

X ____ ____________________________
Patient Signature (Patients over 18) **Date**

____ ____________________________
Parent/Guardian Signature (Patients Under 18) **Date**

____ ____________________________
Witness **Date**

Notice To Recipient Of This Information: This information has been disclosed to you from records, which are protected by federal (42 CFR Part 2) and state laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose

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Below is the only Information Released to Your PCP:

This patient was seen on (date): ____

(Diagnosis) ____

Treatment Plan or Recommendations: ____

____

*****PROVIDER: Fax to Primary Care Doctor and keep original in client file.**