Adult Consent Form Packet

Welcome | Child/Minor Consent Form | Telehealth Consent Form | Standard Authorization Form | HIPPA and Checklist

First Name(Client/Patient)* | M.I. | Last Name* | Date of Birth*

MM/DD/YYYY

HIPAA Acknowledgement

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); obtaining payment from third party payers (e.g. my insurance company); the day-to-d a healthcare operations of your practice.
- I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.
- I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
- I understand that I have the right to request restrictions on how my protected health information issued and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
- I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Checklist

By my signature, I acknowledge that I have received, understand, and agree to abide by the Comprehensive Health Services Office Policies as defined in the outpatient welcome packet that I received. Those policies and procedures include:

- [x] Office Hours and Appointment Schedules
- [x] After Hours Coverage
- [x] Information Sharing
- [x] Clients Beyond our Ability to Treat
- [x] Client Complaints and Grievances
- [x] Termination of Services
- [x] Attendance No Show and Late Cancellation Policies
- [x] Emergency Numbers
- [x] Changes to Insurance and Demographic Information
- [x] Client Rights and Responsibilities
- [x] Consent to Treat
- [x] Authorization to Bill Insurance

Name of Legal Guardian (If applicable) | Relationship to client/patient (if applicable)

Signature of Client/Patient/Legal Guardian*

Clear

Date of Signature*

MM/DD/YYYY

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