Elizabeth M. Atkinson, LPC
(336) 669-0146 confidential voice mail
(336) 740-9137 fax

Client Information for Payment/Insurance

Name: First_____ Last _____ MI ____

D.O.B. _____ Home Phone: _____Cell:_____

Address :_____

City:_____ State: _____ Zip Code: _____

Work Phone: _____ Employer: _____

Occupation: _____ _____
Street

E-mail_____ _____
City State Zip

Is it ok to leave a message at your residence? [] yes []no, at your work? [] yes [] no

Social Security Number: _____

Spouse's Name: _____ DOB:_____

In case of emergency, contact: _____ Phone: _____

Insurance Co: _____

Policy Number: _____ Group Number: _____

Primary Care Physician: _____

Who is financially responsible for this bill? _____

Payment expected at time of service by cash or check. (No petty cash kept in office, will need exact change)

Insurance Information

_____ _____ _____ _____
Name of Insured Relationship ID# Group #

Insured's Employer: _____Insured's Work# _____

Insured's DOB: _____Day/Month/Year

Is it ok to receive mailings at your home related to this office, such as newsletters, workshops, specialty training? [] yes [] no

1201 Battleground Avenue, Suite 104
Greensboro, NC 27408
www.elizabethmatkinson.com

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CONSENT TO DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information" or PHI), excluding psychotherapy notes, by Elizabeth M. Atkinson, MA, LPC in order to carry out treatment, payment, or health care operations (TPO). My specific authorization must be obtained for disclosure of my PHI, including summary of psychotherapy notes, for purposes other than TPO, except in special situations. I have reviewed the Notice of Privacy Practices for a more complete description of the potential disclosures of such information.

I have the right to inspect and obtain a copy of my medical/mental health records, although I understand the Provider has the right to deny such request under certain circumstances. I have the right to have a denial to inspect reviewed by a "reviewing official". A reasonable fee may be charged for providing a copy of my records. I have the right to request amendments to the information in my medical/mental health records, although I understand the Provider has the right to deny such request. I have the right to request an accounting of disclosures of my PHI for purposes other than TPO and those for which I provided authorization. I may submit a written privacy complaint to the address below or to the U.S. Secretary of the Dept. of Health and Human Services, without any action being taken by the Provider against me and without any change in my treatment.

Provider reserves the right to change the terms of its Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed, I may obtain a copy of the revised Notice by requesting a copy.

I retain the right to request that the Provider further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Provider is not required to agree to such requested restrictions; however, if the Provider does agree to by requested restriction(s), such restrictions are then binding on the Provider.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Provider in writing. The revocation shall be effective *except* to the extent that the Provider has already taken action in reliance on the Consent.

The Provider may refuse to treat me if I (or authorized representative) do not sign the Consent portion of this form (except to the extent that the Provider is required by law to treat individuals). If I (or authorized representative) sign the Consent portion and then revoke Consent, the Provider has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that the Provider is required by law to treat individuals).

I ____CONSENT/ ___DO NOT CONSENT TO THE RELEASE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.
I ____HAVE/ ____ HAVE NOT HAD AN OPPORTUNITY TO REVIEW THE PROVIDER'S NOTICE OF PRIVACY PRACTICES.

Date:_____

_____

_

Signature of Patient (or authorized representative)

_____

_

Please print name

Representative's Authority to act on behalf of the Patient:

_____

For Office Use Only: ACKNOWLEDGEMENT OF PRIVACY PRACTICES WAS NOT OBTAINED BECAUSE:

_____

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