**INTERACTIONS COUNSELING & INTERVENTION CENTER, INC.**

CONSENT TO DISCLOSE HEALTH INFORMATION FOR COMMUNICATIONS, PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

Patient Name Phone

Home Address DOB

ACKNOWLEGMENT OF RECEIPT OF PRACTICE’S NOTICE OF PRIVACY PRACTICES

By my signature below, I hereby acknowledge that I have read the Practice’s Notice of Privacy Practices and may request a hard copy for my records.

CONSENT TO TREATMENT AND DISCLOSURE OF MY GENERAL HEALTH INFORMATION

By my signature below I authorize my therapist, , an Independent Clinician contracted with Interactions Counseling and Intervention Center, Inc. (ICIC), to treat me and share my health and insurance information with ICIC for the duration of my treatment with my therapist while she/he is contracted with ICIC. I hereby authorize ICIC to receive and disclose my health information for the purpose of seeking payment from my insurance company, myself or from other designated third parties for treatment by my therapist, and to generally carry on ICIC’s health care operations (i.e. quality assurance).

 By my initials I also authorize my therapist and or ICIC to leave a message on my home or cell phone answering machine/voice mail containing: the name of therapist, time and date of appointment and/or instructions where to return call or other brief message. I also give permission for my therapist or ICIC to leave a message with the following additional family and friends:

 and at the following work numbers.

*I do not want my therapist or ICIC to leave messages for me at any location. (Initial here)*

*Follow these instructions instead:*

CONSENT TO USE EMAIL AND OR TEXT MESSAGING :

 By my initials I hereby authorize my therapist and Interactions Counseling to use email and or text messaging as a form of communication with me or my child. While both my therapist and Interactions will take every precaution to insure confidentiality when using electronic communications, I am aware and understand the risks involved with using email and or texts including that emails and texts are not be guaranteed to be confidential and can potentially be circulated or broadcast worldwide and that electronic communications can be used as evidence in court. My initials indicate my agreement to use these forms of communication at the following addresses and numbers:

I further understand that should I decide to use either form of communication I will initiate this form of contact with my therapist or Interactions staff by contacting them through this medium.

Name and Text phone number:

Name and Email address:

ASSIGNMENT OF INSURANCE BENEFITS:

By my signature below, I authorize medical benefits to be paid to Interactions Counseling and Intervention Center, Inc. on my behalf for any service provided by the Independent Clinician, contracted with the Practice. I understand that I am responsible for all charges, regardless of insurance coverage for the service dates I am treated at Interactions Counseling.

Signature of Patient or Guardian Description of Authority Date

Witness