PERMISSION STATUS

My Initials (all 6 on left) and Signature below indicates the following:

____ I have received a copy of Limits of Confidentiality.
I agree to the above limits of confidentiality and understand their meanings and ramifications.

____ I am authorizing permission to receive treatment by the mental health professional.

____ I have indicated my preference on 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 responsibility 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, APRN, CNS, MSN to be paid to Mary M. Andersen, APRN, CNS, MSN

I understand that I am financially responsible to Mary M. Andersen, APRN, 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.

_____ I understand that APPS will not condition treatment or eligibility for care on my providing this authorization.

Patient Signature/Date Signed: _____/_____/_____

Responsible Party Signature/Date Signed_____ _____/_____/_____

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, APRN, 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, APRN, 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.

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