All new clients using their health insurance coverage to pay for treatment must sign the authorization to release your private information to ProPsych Billing Solutions who will be directly billing your insurance carrier. The other authorization to release or obtain Client Information is optional.

Authorization to Release Client Information to ProPsych Billing Solutions and Insurance Companies

Paul Ruffer, LICSW & LCSW-C 1050 17th St NW Suite 1000
Washington, DC 20036

CLIENT INFORMATION: (Please Print)

Client Name:

_____
(Last) (First) (Middle Initial)

Home Address:

_____Apt # _____

_____
City State Zip Code

Home Phone #: _____-_____-_____ Other Phone #: _____-_____-_____ Sex: ☐ Male ☐ Female

Date of Birth: _____/ _____/ _____ Social Security Number: _____-_____-_____
Month Day Year

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Partner

Occupation: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Full Time Student ☐ Part Time Student

Name of Employer / School:

_____

Previous Mental Health Treatment (within 2 years): ☐ Psychiatrist ☐ Psychologist ☐ LCSW-C ☐ Other

Mental Health Provider: Name: _____

Phone: ____-____-_____

INSURANCE INFORMATION:

Primary Insurance Company: _____ ID Policy #: _____

Group #:_____

Claims Address: _____

Phone #: _____- _____-_____

Policyholder's Name: _____

Date of Birth ____/____/_____ Social Security #_____

Effective Date of Insurance: _____ /_____/_____
Month Day Year

Policy Holder's Employer: _____

Phone #: _____- _____-_____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Person Responsible for Account: ☐ Patient ☐ Parent ☐ Other

_____
Name (if different from client) Date of Birth: ____/_____/_____
Phone # _____-_____-_____

Secondary Insurance (Medicare clients only) _____
ID Policy # _____

Policy Holder Name: _____
Date of birth:_____/_____/_____

AUTHORIZATION TO BILL INSURANCE:

Client or Authorized person's signature: I authorize ProPsych Billing Solutions to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed _____ Date_____

AUTHORIZATION TO RELEASE OR OBTAIN CLIENT INFORMATION AND RECORDS

Client's Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ DOB: _____

I, _____ , authorize _____ to:

____ (send) ___ (receive) the following ___ (to) _____ (from)

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.

____ Academic testing results	____ Psychological testing results
____ Behavior programs	____ Service plans
____ Progress reports	____ Summary reports
____ Intelligence testing results	____ Vocational testing results
____ Medical reports	____ Entire record, except progress notes
____ Personality profiles	____ *Psychotherapy Notes
____ Psychological reports	___ Other, specify_____

The above information will be used for the following purposes:

____ Planning appropriate treatment or program
____ Continuing appropriate treatment or program
____ Determining eligibility for benefits or program
____ Case review ____ Updating files
____ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: __Self __Parent/legal guardian __Personal representative
__Other (describe)_____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: ___/___
_____/_____
Parent/guardian/personal representative (if applicable)
Signature: _____ Date: ___/___/_____
Witness (if client is unable to sign)
Signature: _____ Date: ___/___/_____