

Strength of Mind

Contact Information

Patient			Responsible Party		
Name			Name		
Address			Address		
City	State	Zip	City	State	Zip
Home Ph	Marital Status	Sex	Home Ph	Marital Status	Sex
SSN#	Birthdate		SSN#	Birthdate	
Employer	Occupation		Employer	Occupation	
Address			Address		
City	State	Zip	City	State	Zip
Work Ph	Cell Ph		Work Ph	Cell Ph	
Emer Contact/Relation	Phone #		Referred By:		
Email:			Email:		
Pharmacy:			Phone #		

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of authorization to be used in place of the original.

Signature: _____ Date: _____

I hereby authorize Strength of Mind to apply for benefits on my behalf for covered services rendered by me; I request the payment from my insurance company be made directly to Strength of Mind.

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature: _____ Date: _____

Patient, Parent, or Legal Guardian

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, Strength of Mind originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the healthcare professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bill
- a means for a third-party payer to verify that services were billed as actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that, Strength of Mind, reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Strength of Mind is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you**that the information authorized for release may include records which may indicate the presence of a noncommunicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

In addition to the releases outline above, information may be released to the following individuals/organizations for the indicated purpose:

You ____ may ____ may not leave appointment reminders on my message service or machine.

You ____ may ____ may not leave appointment reminders on my personal email.

By signing below, you are stating that you have read and understood the policy statement and you have had your questions answered to your satisfaction.

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

By signing below, I have read and understand Strength of Mind's office policies. Also, I have read my rights and responsibilities as a patient at Strength of Mind.

Name of patient (please print): _____

Signature: _____ **Date:** _____

Signature of Parent/Gaurdian: _____ **Date:** _____