

**Please type inside the shaded area or click the select area.**

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| **client information form** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Client ID#:** | | | | |
| **Name:** | | | | | | | | | | | | | | | | **DOB:** | | | | | | | **Age:** | | | | **Sex:** | | | | | **SS#:** | | | | | | | |
| **Address:** | | | | | | | | | | | | | | | | | | | | **City:** | | | | | | | | **State:** | | | | | | | | | **Zip:** | | |
| **Hm Ph #:** | | **Cell Ph#:** | | | | | | | | | | | | | **Other #:** | | | | | | | | | | **Email:** | | | | | | | | | | | | | | |
| **How may we contact you?** | | | | | | | | | | | | | | | | | | | | | | **May we leave a message?** | | | | | | | | | | | | | | | | | |
| **Marital Status:** | | | | | | **Living Arrangement:** | | | | | | | | | | | | | | | | | | **Minor Parent/Guardian Name:** | | | | | | | | | | | | | | | |
| **Occupation:** | | | | | | | | | | | | | | **Employer:** | | | | | | | | | | | | | | | | | | | | **Employer Ph #:** | | | | | |
| **Emergency Contact Name:** | | | | | | | | | | | | | | | | | | | **Ph #:** | | | | | | | **Relationship to client:** | | | | | | | | | | | | | |
| **Are you a  new or  returning client?** | | | | | | | | | | | | | | **If returning client, when was your last visit?** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Service(s) Requested:** | | | | | **Referral Sources:** | | | | | | | | | | | | | | | | **Source Ph #:** | | | | | | | | **Source Email:** | | | | | | | | | | |
| **insurance information** | | | | | | | | | | | | | | | | | | | | | | **OFFIC USE ONLY** | | | | | | | | | | | | | | | | | |
| **Responsible Party:** | | | | | | | | | | | | | | | | | | | | | | **Insurance Provider:** | | | | | | | | | | | | | | | | | |
| **Subscriber Name:** | | | | | | | | | | **DOB:** | | | | | | | **Sex:** | | | | | **Address:** | | | | | | | | | | | | | | | | | |
| **Address:** | | | | | | | | | | | | | | | | | | | | | | **City:** | | | | | | | | | | | | | | **State:** | | | **Zip:** |
| **City:** | | | | | | | | | | | **State:** | | | | | | | **Zip:** | | | | **Ph #:** | | | | | | | | | **Fax#:** | | | | | | | | |
| **Ph #:** | **Email:** | | | | | | | | | | | | | | | | | | | | | **Email:** | | | | | | | | | | | **Website:** | | | | | | |
| **Subscriber’s ID#:** | | | | **Client Relationship To Subscriber:** | | | | | | | | | | | | | | | | | | **Claim Address**: | | | | | | | | | | | | | | | | | |
| **Subscriber’s Employer:** | | | | | | | | | | | | | | | | | | | | | | **Insurance Type:** | | | | | | | | | | | | | | | | | |
| **Policy/Group Name**: | | | **Group/FECA#:** | | | | | | | | | | | | | | | | | | | **In Network:** Yes No | | | | | | | | **Electronic Filing**: Yes No | | | | | | | | | |
| **Authorization Required: Yes No** | | | | | | | **Author #:** | | | | | | | | | | | | | | | **Claim Inquiry Ph#:** | | | | | | | | **Claim Processing:** | | | | | | | | | |
| **CoPay: $** | | | | | | | **Specialty CoPay: $** | | | | | | | | | | | | | | | **Insured’s Effective Date:** | | | | | | | | **Insured’s Terminate Date:** | | | | | | | | | |
| **Is there another Health Plan: Yes No** | | | | | | | | | | | | | | | | | | | | | | **Deductible: $** | | | | | | | | **Deductible Met:** Yes No | | | | | | | | | |
| **Subscriber Name:** | | | | | | | | | | **DOB:** | | | | | | | **Sex:** | | | | | **Limit: $** | | | | | | | | **Amt Satisfied: $** | | | | | | | | | |
| **Subscriber’s ID#:** | | | | | **Client Relationship To Subscriber:** | | | | | | | | | | | | | | | | | **Comments:** | | | | | | | | | | | | | | | | | |
| **Policy/Group Name**: | | | | | **Group/FECA#:** | | | | | | | | | | | | | | | | |
| **Authorization Required: Yes No** | | | | | | | | **Author #:** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **CoPay: $** | | | | | **Specialty CoPay: $** | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **Current concerns / Problems** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Describe Problem:** | | | | | | | | | | | | | | | | | | | | | | **List your goal(s) for counseling related services?** | | | | | | | | | | | | | | | | | |
| **Problem Began** | | | | | | | | | **Problems Affect:** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Have you received treatment for this problem before?** Yes No | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **Is there a Family History of this problem?** Yes No | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **Current Health Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary Care Physician**: | | | | | | | | | | | | | | | | Ph#: | | | | | | **Specialist:** | | | | | | | | | | | | | | | | Ph#: | |
| **Medication:** | | | | | | | | | | | | **Medication:** | | | | | | | | | | | | | | | **Medication:** | | | | | | | | | | | | |
| **History of serious physical/medical health condition?** Yes No **Describe:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **History of Psychological/Educational Evaluation** Yes No **Describe:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **behavioral/emotional symptoms**  **Check all of the following symptoms you are currently experiencing.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Loss of interest in work, school, daily activities | | | | | | | | | | | | | Hyperactive, Impulsive, out of control | | | | | | | | | | | | | | | Bizarre or Repetitive thoughts/behavior | | | | | | | | | | | |
| Loss of interest in sex / maintaining arousal | | | | | | | | | | | | | Unexplained aches, pains, or muscle tension | | | | | | | | | | | | | | | Difficulty making decisions | | | | | | | | | | | |
| Loss of interest in hobbies/social activities | | | | | | | | | | | | | Hallucinations / hearing voice, seeing things | | | | | | | | | | | | | | | Suspicious/distrust of others | | | | | | | | | | | |
| Loss / change in appetite | | | | | | | | | | | | | Delusions / Incorrect inference | | | | | | | | | | | | | | | Hyperventilation, or trouble breathing | | | | | | | | | | | |
| Trouble sleeping / Insomnia | | | | | | | | | | | | | Detached, disconnected or weird | | | | | | | | | | | | | | | Heart palpitations or chest pain | | | | | | | | | | | |
| Unintentional weight gain or loss | | | | | | | | | | | | | Angry/Hostile | | | | | | | | | | | | | | | Headaches, dizziness, or faintness | | | | | | | | | | | |
| Feeling sad, helpless, or trapped | | | | | | | | | | | | | Mood swings | | | | | | | | | | | | | | | Hot flashes, sweating, or chills | | | | | | | | | | | |
| Feeling guilt | | | | | | | | | | | | | Thoughts of harming self or others | | | | | | | | | | | | | | | Stomach upset, cramps, or nausea | | | | | | | | | | | |
| Worry, panic or fear | | | | | | | | | | | | | Preoccupation with death or dying | | | | | | | | | | | | | | | Frequent urination or diarrhea | | | | | | | | | | | |
| Restlessness, irritability, nervousness | | | | | | | | | | | | | Crying spells for no apparent reason | | | | | | | | | | | | | | | Alcohol or drugs use | | | | | | | | | | | |
| Loss of energy, fatigued, or weak | | | | | | | | | | | | | Trouble concentrating or mind going blank | | | | | | | | | | | | | | | Other: | | | | | | | | | | | |

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| **Client's Signature:** | **Parent/Responsible Party's Signature:** | **Date:** |

 **FINANCIAL POLICY**

Thank you for choosing ***Eclectic Cognitive Behavioral Center*** (*Eclectic*) to serve you and your family’s behavioral health needs. As part of this relationship, we wish to establish our expectations of your financial responsibility as outlined in our ***Financial Policy***.

1. **Service fees**: Payment is due at the time of service.

* ***Diagnosis Interview/Intake: $175*** ***per unit (****45-50-minute session, billable in 15 minute increments+ Add-on $65).*
* ***Individual Session***: **$** **125** per unit *(45-50-minute session, billable in 15 minute increments+ Add-on $65).*
* ***Family, Relationship, and/or Group Session***: **$ 70**  per unit (45-50-minute session, billable in 15 minute increments).
* ***Assessment/Testing***: fees vary on the types of assessment and instruments used.
* ***Review of Correspondence* (emails, letter, form, telephone calls/messages):** $**35** per 1-15 minutes.
* ***Written Correspondence /Report:*** $150 per hour with 1 hour minimum.
* ***Completion of Medical Form*:** $25 (1 – 3 pages) $5 per page thereafter.
* ***Medical Record Copies*:** $15.00 for record search; $1 copy per page for the first 10 pages, $ .50 per page thereafter. Please allow 10-14 days for the completion of medical forms and/or copies of medical records.
* ***Court Service fees***: vary based on the types of services.
* ***Late / Missed / Canceled appointments*** *with less than 24 hours’ notice*: **$75.00**
* ***Postage***: actual cost of postage to send records/correspondence.
* ***Returned Checks:*** **$25.00 *Credit Card Processing:* $3.00**
* **Invoice Billing:** 5% interest charge (25% Annually) on accounts not paid within 30 days

​Please allow 10 - 15 business days for the completion of medical forms and/or medical records.

1. **LATE/CANCELLED/MISSED APPOINTMENTS:** If you are late for an appointment, your session will end at the originally scheduled end time, and you will be charged the full unit cost. You will be billed for Missed/Canceled Appointments with less than 24 hours’ notice. Such fees are not covered by insurance plan and is your responsibility.
2. **CO-PAYMENTS/DEDUCTIBLES:** Co-payments, deductibles, and other fees not covered by your insurance policy are due at the time of service; and must be secured by Credit Card.
3. **INSURANCE:** Your insurance is a contract between you and your insurance provider. While we may assist clients in filing insurance claims, you (Responsible Party) are responsible for all charges incur by you, your spouse, or dependents*.* Should your insurance provider deny or reject a claim for payment of services due to: 1) not efficacious (not medically or therapeutically necessary); 2) ineligibility (not covered by your policy), or 3) the policy has expired, or is not in effect for you, your spouse, or dependents; 4) your submission of inaccurate, or incomplete information; 5) deductibles not met; or 6) failure to pay a claim within 30 days, the balance will be transferred to your account and you will be responsible for payment. If *Eclectic* receives payment at a later date, you will be reimbursed.

A valid insurance card, provisions of insurance coverage, and notification of changes in benefits must be provided at the time of service. If a valid insurance card is not presented, or insurance benefits cannot be verified you will be responsible for charges at the time services.If ***Eclectic*** receives an insurance payment at a later date, you will be reimbursed. You are responsible for providing *Eclectic* with accurate information, so a claim can be properly submitted to your insurance provider.

Our efforts to verify insurance coverage, related benefits, and to submit claims on your behalf requires your authorization or consent to the *Release Information to Insurance / Third Party Payer.*  See ***Confidentiality, Privileged Communication, & Record Policy*** regarding the type of information that may be requested by insurance companies and other Third-Party Payers.

1. **No Insurance / High Deductible:** Clinical Care Packets are available for individuals with NO Insurance or High Deductibles. To be eligible, clients must select a packet at their first session; and secure the packet with a credit card. The credit card will be billed prior to each session. Clinical Care Packets expire one year from the date of purchase. For individuals with High Deductibles, we will kindly submit insurance claims on our behalf.
2. **Payment Options:** Payment is due at the time of service. We accept cash, checks, credit cards and various insurance plans. If your insurance provider is one with which *Eclectic* participates, we will assist you in the submission of claims. A 5% per month (25% Annually) interest fee will be accessed on accounts with balances +30 days of Invoice date. Accounts may be forwarded to a collection agency, and you will be responsible for all related collection fees if 1) your account becomes delinquent +90 days and you have not established a *Payment Plan*; and/or 2) you fail to honor your *Payment Plan.* Also, you will be discharged from behavioral/mental health care services.
3. **CREDIT CARD AUTHORIZATION:** All accounts except EAP must be secured with a credit card for fees not covered by insurance (co-pays, missed/canceled appointments, outstanding balances). An Invoice will be sent to you with service dates, description, and fees. If payments are not received within 30days of Invoice, your credit card will be charged, and a receipt of charges will be sent to you. You may specify a maximum dollar amount that we are authorized to charge each month.

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| My signature below affirms, that I have read, understand, and agree with the provisions of this ***Financial Policy***. I authorize ***Eclectic*** to keep a copy of my credit card on file for future payments and to charge all balances accrued up to $      a month. I understand that if a payment is denied by the credit card on file, I will not be able to schedule any future appointments until the balance has been paid in full, and my account may be sent to an outside collection agency, and I will be discharged from the behavioral/mental health services.  I understand that I am responsibility for notifying ***Eclectic*** of any changes (name, contact information, insurance coverage, etc.) to ensure current information to contact me and/or process claims are available. I understand that the information contained herein is considered a summary; and if I have questions or concerns about specific situations or any aspects of policy, I should discuss them with ***Eclectic***. | | | |
| **Client's Name (PRINT):** | | **Parent/Responsible Party's Name:** | |
| **Client's Signature:** | **Parent/Responsible Party's Signature:** | | **Date:** |

***It is your responsibility to notify Eclectic of any patient information changes (i.e. address, name, insurance information, etc).***

**(review otherside**) **(Revised: 01/2020)**

 **Confidentiality, Privileged COMMUNICATION, & record policy**

**Confidentiality**. Confidentiality is an ethical standard set forth by our profession, whereas privileged communication is a legal right that protects clients from the disclosure of Protected Health Information (PHI) without their informed consent. Privacy, according the Health Insurance Portability and Accountability Act (HIPAA) regulation, is an individual's right to control access and disclosure of their PHI.

HIPAA requires that information provided by an individual to health care providers including notes and observations about the their health will not be used for purposes other than treatment, payment, health care operations or for the specific purposes described in the Privacy Rule. The Privacy Rule does not prevent health care providers from discussing client/patient information with fellow providers for treatment purposes.

**Limits of Confidentiality.** There are situations where ***Eclectic Cognitive Behavioral Center*** *(****Eclectic****)* may be required or permitted to disclose information without the client's authorization or consent. These legal exceptions include:

* ***Duty to Warn and Protect***: When serious and foreseeable harm to client or others is evident, ***Eclectic*** is required to notify the appropriate legal authorities; make reasonable attempts to notify the family of the client; and warn the intended victim.
* ***Abuse, Neglect or Exploitation of a Child or Vulnerable Adult***: When abuse, neglect or exploitation of a child or vulnerable adult is evident or suspected *Eclectic* is required to report such information to the appropriate social service and/or legal authorities. (Vulnerable adult is defined as a person who is 18 years of age or older who has a substantial mental or functional impairment.)
* ***Prenatal Exposure to Controlled Substances***: When a client discloses that he/she has exposed a fetus or child to a controlled substance that is potentially harmful during pregnancy, ***Eclectic*** is required to notify the appropriate legal authorities.
* ***Court Orders / Legal* Disclosure**: When information is requested by a valid subpoena, court order, or required by law ***Eclectic*** is required to release such information to the appropriate legal authorities.
* ***Minors/Guardianship***: Parents or legal guardians have the right to access records of non-emancipated minor clients. Thus, when a parent or legal guardian of a non-e**mancipated minor, request information, *Eclectic*** is required to release confidential information to the parent or legal guardian making the request.

**Insurance/Third Party Payer**: When you or the ***Responsible Party*** authorize payment of benefits by an Insurance companies and other third-party payers ***Eclectic*** may be required to release confidential information for payment of services to include name, DOB, social security #, services rendered, dates/times of services, diagnosis/description of symptoms, and treatment goal/plan.

***Eclectic***respects each client's rights to privacy. To the extent required by law, clients are informed, involved in the disclosure decision-making process, and provide Informed Consent before confidential information is disclosed. When circumstances require the disclosure of confidential information, only essential information is revealed.

**Protected Health Information.** Protected Health Information (PHI) means any information that identifies an individual, and relates to at least one of the following:

* The individual’s past, present or future physical or mental health.
* The provision of health care to the individual.
* The past, present or future payment for health care.

Information is deemed to identify an individual if it includes either the individual’s name or any other information that could enable someone to determine the individual’s identity (e.g., address, age, Social Security number, e-mail address).

**Medical Records**. In an effort to protect confidentiality and privileged communication, handwritten notes are transposed into a typewritten/electronic format. Once transposed, written notes are shredded, and only typewritten/electronic notes are maintained. Medical rrecords are maintained for seven (7) years after the client’s last visit, and seven (7) years pass the 18th birthday of minors. Request for Medical Records will be made available within 10 - 14 days, following a signed authorization or consent to the Release of Information. See ***Financial Policy*** regarding fees for copies of medical records.

**Client Contact.** I understand that the following mediums are not a secure way of preserving confidentiality, nor a reliable method of contacting clients or ***Eclectic*** in crisis/non-crisis situations. Yet, I consent to ***Eclectic*** contacting me via the following mediums**:** Hm Cell Email Mail Other:       Messages may be left via: Voicemail Email Person that answer

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| I have read, understand, and agree with the provisions of this ***Confidentiality & Privileged Communication Policy***. I understand that protected health information is collected and stored on databases, and that at all times my privacy is treated with the highest regard. I understand that ***Eclectic*** will make reasonable efforts to disclose only that information which is necessary for securing payment, conducting standard health care operations, and that which is required by law.I understand that the information above is considered a summary; and if I have questions or concerns about specific situations or any aspects of this or other policies, I should discuss them with ***Eclectic***. | | | |
| **Client's Name (PRINT):** | | **Parent/Responsible Party's Name:** | |
| **Client's Signature:** | **Parent/Responsible Party's Signature:** | | **Date:** |

**(review otherside**) **(Revised: 01/2020)**

 **Consent to Treatment**

I understand that:

* my involvement and cooperation are required and is keys to effective of treatment; that regular attendance and completion of therapeutic assignments are essential; and that failure to do so may result in termination of services.
* all identifiable, diagnosis and treatment information are confidential and will not be released to any agency or individual without my written consent, except when required by law, and conducting standard health care operations.
* the provision of treatment requires communication of Protected Health Information (PHI) among Eclectic’s administrative staff, and my insurance/third-party payer; and that PHI is collected and stored on an electronic database, and that at all times my privacy and care will be treated with the highest regard.
* Eclectic may consult with other health care providers in order to provide the best treatment possible for me; and that my written consent may not be required when PHI is not released for such purposes. However, should it be necessary to consult with my Primary Care Physician/Specialist about my specific diagnosis and treatment, my written consent is required.
* all consent/authorizationsshall remain in effect until further notice and may be modified or revoked at any time; and that revocation of consent may result in a loss of insurance benefits and services.

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| **MinoR Client**  **Parent/Guardian authorization or consent to treatment children under the age of 19 is required!** | | | | | | | | | |
| **Father’s Name:** | | | | | **Mother’s Name:** | | | | |
| **Address:** | | | | | **Address:** | | | | |
| **City:** | | | **State:** | **Zip:** | **City:** | | | **State:** | **Zip:** |
| **HmPh#:** | **CelPh#:** | **Email:** | | | **HmPh#:** | **CelPh#:** | **Email:** | | |
| **If parents are divorced/separated, Custodian Parent is**?  Father  Mother  Share **Both parents aware of child’s treatment?** Yes  No | | | | | | | | | |
| Additionally, I understand that:   * parental/guardian participation is required in the treatment of a minor; and that Family Counseling and Consultant is necessary in the treatment of a minor; which may result in additional fees. * my child's regular attendance and completion of therapeutic assignments are essential; and that failure to do so may result in termination of services. I understand that my failure to participate in *Family Sessions* may result in termination of services. * treatment planning may require consultation with others involved with my child’s care in order to provide the best treatment possible. Should it be necessary to consult with my child’s Primary Care Physician/Specialist or Teacher, my written consent is required. * children less than 15 years of age shall be accompanied by an adult entrusted by me (parent/guardian), unless otherwise stated herein. | | | | | | | | | |

**I give consent to:**

**Treatment by PLPC/Counselor Interns**. I understand that *Eclectic* is a training center for Provisional Licensed Professional Counselor (PLPC), and Counselor Interns. I understand that my therapist may be a PLPC**/**Counselor Intern/Supervisee. I understand that all Interns/Supervisee are supervised by a licensed clinician, and that PHI will be discussed with the respective supervisor.

Use of video/audio recordings. I understand that as a Training Site Eclectic may use video and/or audio recordings for clinical observation to promote quality care, NOT to include marketing. I understand that all staff will respect and protect the confidentiality of information; and that recordings shall be the property of the *Eclectic*. I understand that my objection to the use of PLPCs, Interns, and/or recordings shall in no way jeopardize my relationship with Eclectic.

***I understand that the information above is a summary; and that I should direct questions or concerns regarding Eclectic’s policies to staff.***

My signature below is an acknowledgement of my receipt, understanding, and agreement to the policies referenced herein.

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| --- | --- | --- | --- |
| **Client's Name (PRINT):** | | **Parent/Responsible Party's Name:** | |
| **Client's Signature:** | **Parent/Responsible Party's Signature:** | | **Date:** |

**FOR OFFICE USE ONLY**

Written acknowledgment of Consent could not be obtained because:

❑ Client, Parent/Guardian/Responsible Party refused to sign ❑ Emergency situation ❑Communications barriers

❑ Other

|  |  |  |  |
| --- | --- | --- | --- |
| **Revocation of consent TO TREAT** | | | |
| **Client's Name (PRINT):** | | **Parent/Guardian/Responsible Party's Name:** | |
| **Client's Signature:** | **Parent/Guardian/Responsible Party's Signature:** | | **Date:** |

**(review otherside for Minors**) **(Revised: 01/2020)**

Consent **TO Release Information to Insurance / Third Party Payer**

**(Valid Insurance Card Required)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Insurance/Third Party Payer:** | | **Phone#:** | | **Fax:** | |
| **Address:** | **City:** | | **State:** | | **Zip:** |

I understand that:

* Protected Health Information (PHI) may include name, DOB, social security #, services rendered, dates/times of services, diagnosis/description of symptoms, treatment goal/plan and prognosis, etc.; and that authorization to release PHI to my insurance /third part payer shall remain valid 365 days after the last date of my treatment; or I revoke this release.
* The provision of treatment requires communication of PHI among Eclectic’s administrative staff, and my insurance / third-party payer. Such PHI will be limited to the provisions of insurance benefits and will be accessible only to persons necessary is to determine payments and/or insurance benefits.
* PHI is collected and stored on an electronic database, and that at all times my privacy and care will be treated with the highest regard.
* My medical insurance is a contract between me, and my insurance provide, and I am responsible for payment.
* Permission must be granted by the parent/ guardian of a client less than 18 years of age. Exceptions are made in circumstances wherein federal or state law allows minors to seek certain treatment or services without parental consent.
* This consent/authorizationshall remain in effect until further notice; and it may be modified or revoked at any time. Revocation of consent may result in a loss of insurance benefits and services.

**Consent/Authorization**

I consent/authorize ***Eclectic Cognitive Behavioral Center*** to send and/or receive Protected Health Information (PHI) to/from the insurance company(s) and/or other third-party payers noted above for the purpose of receiving payment for services.

My signature below is an acknowledgement of my receipt, understanding, and agreement to the conditions set forth by the policies referenced herein.

|  |  |  |  |
| --- | --- | --- | --- |
| **Client's Name (PRINT):** | | **Parent/Responsible Party's Name:** | |
| **Client's Signature:** | **Parent/Responsible Party's Signature:** | | **Date:** |

**FOR OFFICE USE ONLY**

Written acknowledgment of Consent could not be obtained because:

❑ Client, Parent/Guardian/Responsible Party refused to sign ❑ Emergency situation ❑Communications barriers

❑ Other

|  |  |  |  |
| --- | --- | --- | --- |
| **Revocation of consent** | | | |
| **Client's Name (PRINT):** | | **Parent/Guardian/Responsible Party's Name:** | |
| **Client's Signature:** | **Parent/Guardian/Responsible Party's Signature:** | | **Date:** |

**(REVIEW OTHERSIDE FOR MINORS) (Revised: 01/2020)**



***Renewing The Mind* ▲ *Transforming Lives***

**1733 Wooddale Blvd ▲ Baton Rouge, LA 70806 ▲ 225-924-2800Phone ▲ 225-924-9280 Fax ▲ eclecticcbc@gmail.com ▲ www.eclecticcbc.net**

Consent to consult medical practitioner

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medical Practitioner:** | | **Phone#:** | | **Fax:** | |
| **Address:** | **City:** | | **State:** | | **Zip:** |

I understand that:

* some symptoms have medical or biological origins and may be consistent with a serious mental or physical health condition warranting consultation with my Primary Care Physician, and/or other health care practitioner.
* effectual treatment may require consultation with other health care providers in order to provide the best treatment possible for me; and that my written consent may not be required when PHI is not released for such purposes. However, should it be necessary to consult with my Primary Care Physician/Specialist about my specific diagnosis and treatment, my written consent is required.
* in consulting with other health care provider, PHI will be limited to the provisions health care and will be accessible only to persons necessary is for diagnosis, treatment planning, and coordinated health care.
* if the client is less than 18 years of age, permission must be granted by the child's parent or legal guardian. Exceptions to this policy are made in circumstances wherein federal or state law allows minors to seek certain treatment or services without parental consent.\
* all ***consent/authorizations*** shall remain in effect until further notice; and it may be modified or revoked at any time. Revocation of consent may result in a loss of insurance benefits and services.

I consent/authorize ***Eclectic Cognitive Behavioral Center*** consulting with the referenced Medical Practitioner noted above for the purpose of diagnosis, treatment planning, and coordinated health care.

My signature below is an acknowledgement of my receipt, understanding, and agreement to the conditions set forth by the policies referenced herein.

|  |  |  |  |
| --- | --- | --- | --- |
| **Client's Name (PRINT):** | | **Parent/Responsible Party's Name:** | |
| **Client's Signature:** | **Parent/Responsible Party's Signature:** | | **Date:** |

**FOR OFFICE USE ONLY**

Written acknowledgment of Consent could not be obtained because:

❑ Client, Parent/Guardian/Responsible Party refused to sign ❑ Emergency situation ❑Communications barriers

❑ Other

|  |  |  |  |
| --- | --- | --- | --- |
| **Revocation of consent** | | | |
| **Client's Name (PRINT):** | | **Parent/Guardian/Responsible Party's Name:** | |
| **Client's Signature:** | **Parent/Guardian/Responsible Party's Signature:** | | **Date:** |