AUTHORIZATION TO COMMUNICATE PROTECTED HEALTH INFORMATION TO INSURANCE

WESTERN PSYCHOLOGICAL & COUNSELING SERVICES, P.C. (WPCS)

Your signature on this form will authorize WPCS to receive and/or disclose private information about you. Health information is protected by federal and state law and by WPCS policy. Do not sign this authorization unless it is completed in full and in your best interest.

Client Name: _____ Date of birth: _____
Address: _____ Social Security #: _____
City: _____ State:_____ Zip:_____

With my signature below, I authorize Western Psychological & Counseling Services to send information to:
Insurance Company: _____ Subscriber: _____
SSN# / ID Number: _____ Group/Policy #:_____

Purpose for the disclosure:
☒ Authorization to bill insurance named above

Information to be released: (Information to be disclosed MUST be initialed)

___☒ Psychological history
___☒ Psychological evaluation or reports
___☒ Diagnosis
___☒ Treatment plan or summary
___☒ Progress notes
___☒ Chemical dependency information
___☐ HIV or AIDS information
___☐ Other:_____

This authorization will expire:

___☒ 90 days after completion of treatment and insurance and client payment in full

WPCS needs to know if clients have either Medicare or Medicaid insurance coverage. It is the responsibility of all clients to inform WPCS of their insurance status. Please check ☒ all applicable items below: I have insurance coverage with:

☐ Medicare ☐ Medicaid/OHP ☐ Medicaid Non-OHP (Open Card) ☐ Medicaid CUP ☐ Medical Coupons ☐ None

This coverage is my: ☐ Primary insurance coverage ☐ Secondary insurance coverage ☐ N/A

REQUIRED STATEMENTS:

You do not need to sign this authorization. Refusal to sign the authorization will not prevent you from receiving mental health and/or drug/alcohol treatment at Western Psychological & Counseling Services, unless: the health care services are solely for the purpose of providing health information to someone else and the authorization is needed to make the disclosure.

If you do not sign this authorization, Western Psychological & Counseling Services will not be able to bill your insurance. Clients will be required to pay "Cash Pay" based on a fair and customary rate for all mental health and/or drug/alcohol treatment at Western Psychological & Counseling Services.

You may end this authorization in writing at any time. If you revoke your authorization, the information described may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made cannot be undone. To revoke this authorization, please request the form from our front office or your provider. Complete the form and return it to your provider.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

Client (or personal representative) signature: _____ Date:_____
(Client signature required if over 14 years of age)

Subscriber's signature: _____ Print Name:_____
(Ages 14-24, subscriber must sign form or if client is a dependent on insurance policy)

❖ If signed by a personal representative of the client, please complete the following:
Printed personal representative's name: _____
Authority of personal representative: ☐ Parent ☐ Legal guardian ☐ Power of Attorney / Healthcare ☐ Other_____