Carol Harvey MFT
204 G Street, Suite 205 Petaluma, CA 94952 | 707-765-2635

Disclosure statement/Informed Consent

Welcome! As we begin our work together, I would like you to know my philosophical approach to therapy. I view therapy as a collaborative endeavor. Much of the success achieved will depend on our working relationship.

So that therapy may be of maximum benefit to you, I ask you to agree to the following:

- Be on time for your appointments.
- Attend sessions as scheduled, since continuity is an important component of successful therapy.
- Call **at least 48 hours** in advance if you must cancel or change a scheduled appointment. A minimum notice of 48 hours gives me an opportunity to offer the appointment time to someone else.

Risks and Benefits of Therapy

Therapy is a process in which we discuss a myriad of issues, events and experiences for the purpose of creating positive change. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits, including, but not limited to: reduced stress and anxiety; a decrease in negative thoughts and behaviors; improved interpersonal relationships; increased comfort in social, work, and family settings; increased capacity for intimacy; increased self-confidence. Such benefits may also require substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above. If you have any questions or concerns about your progress at any point in therapy, please bring them up for discussion.

Fees

My fees are based on a 45-50 minute hour and are to be paid at the beginning of each session. Writing out your check beforehand allows more time for the therapy.
Appointments canceled with less than 48 hours notice will be billed and shall be paid in full. Insurance companies do not cover missed appointments. This means I will charge you your usual co-pay plus the portion that your insurance typically covers. I do give consideration to emergency situations.
I do not charge for short phone calls (5 minutes or less). Longer calls or additional work requested by you will be prorated and billed at your established rate.
Fees are subject to an annual increase. You will be given a minimum of one month's notice of any increase.
I charge my full fee, at the time of service, for any work requested by you or on your behalf regarding the legal system.

Ethical responsibilities

As a licensed marriage and family therapist, I am legally and ethically required to keep conversations with (and information about) you in confidence. No information will be released without your written permission, except where mandated or permitted by law. I am required or permitted to break confidentiality in circumstances such as but not limited to:

- Reasonable suspicion or knowledge of child abuse.
- Reasonable suspicion or knowledge of elder or dependent adult abuse.
- Determination that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others.

I have a right to terminate therapy under such circumstances as: 1) you are delinquent in your payments **or** 2) it is my determination that the therapy or our therapeutic relationship is not working for you and you would be better served with a referral to another provider.

If you wish to end therapy and we haven't yet discussed it, please bring this up for discussion in a session so that we can bring closure to our work together. If appropriate, we can clarify your needs and I can give you referrals.

Psychotherapist-Patient Privilege

Information disclosed by you, as well as any record created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between a therapist and a client in the eyes of the law. Typically, the client is the holder of the psychotherapist-patient privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on your behalf (meaning I will not disclose any information) until instructed, in writing, to do otherwise by you or your representative.

Professional Consultation
As part of my commitment to provide quality service I participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you.

Records and Record Keeping
I may take notes during sessions, and will also produce other notes and records regarding your therapy. These notes constitute my clinical and business records, which by law, a therapist is required to maintain. Such records are the sole property of Carol Harvey MFT. I will maintain your record for ten years following termination of therapy. After ten years, records will be destroyed in a manner that preserves confidentiality.

Communication & Availability
You are welcome to leave me a confidential voicemail at any time at 707-765-2635 or email me at carolharveymft@gmail.com. I check my voice and email messages many times each day. I will make every effort to respond quickly. However I cannot guarantee that calls will be returned immediately. If you have not received a response from me within 24 hours, please call again.

If I need to reach you outside of our sessions, I will typically call or else the same method you use to reach me. If you have given me permission, I may text or email you. I sometimes text appointment reminders, if requested. Since calls to or from cell phones, e-mails, and texts are not completely secure and confidential, I will be very brief. In texts, I will not identify myself as a therapist. I urge you to be very brief in any texts or emails and to not include any therapy-related content.

Emergencies
I am unable to provide 24-hour crisis service. In the event that you feel unsafe or require immediate medical or psychiatric assistance, call 911 or Sonoma County Psychiatric Emergency Service at 707-576-8181.

Privacy
Since I live in Petaluma, it is possible we may run into each other as we go about our daily lives. To protect your privacy, I will not acknowledge you first. If you say hello or wave, I will respond in kind.

Social Media
It is my policy to dismiss any friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I take this position out of the utmost respect for your confidentiality and our mutual privacy.

Please keep a copy of this form for future reference or download the latest version of my policies at www.carolharveymft.com. If, at any time, you have questions, concerns, or suggestions about any aspect of my practice, please let me know. I value your feedback.

Statement of Understanding
I understand that I have a right to a copy of this agreement. I have had any questions I may have had, answered to my satisfaction. **I have read, understand, and agree to abide by these policies and consent to participate in therapy with Carol Harvey MFT.**

client	date	client	date
client	date	client	date
client/parent/guardian	date	client/parent/guardian	date

Carol Harvey MFT
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Client Profile

(Use back if necessary)

Date: _____ Last name(s) of individual, family or couple: _____

Address: _____
City zip code

□ E-mail address (es): _____ □ _____

□ Home phone number: _____

□ Work phone number: _____

□ Cell phone number(s): _____ □ _____
Is it OK to text you appointment reminders? Y N

NOTE: Text reminders are an occasional courtesy. Do not depend on them.

When I need to reach you, please indicate (✓) which of the above ways/numbers you prefer that I use.

Starting with you, please list relevant household or family members (whether attending these sessions or not):

name	age	birthdate	relationship	living at home?
			self	

Primary care physician: _____phone number: _____

Please list any current &/or significant medical conditions (illnesses, surgeries, allergies, etc.):

Please list any medications you are currently taking:

medication	dosage	reason	date started

Person to contact in case of emergency: _____

phone number(s): _____ relationship: _____

Are you now or have you been in therapy before? _____ if so, please list provider(s) & dates:

Reason you are seeking therapy at this time:

Please let me know how you were referred to me _____

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Financial Agreement

Financially Responsible Person

Name: _____ relationship to client: _____

Address (if different than profile sheet): _____

Phone numbers (if different): home _____ work _____ cell _____

Payment policy

Fee or insurance co-payment is due at each session. I accept cash, checks, most credit cards and HSA cards. Any returned checks are subject to additional collection fees equal to the bank charges I incur.

Fees

My usual fee per 50 minute session is $140.00. In order to make therapy more accessible for clients who might otherwise not be able to afford it—I offer a limited number of reduced fee slots. The fee we have agreed to $_____. Fees are subject to an small annual increase with a minimum of one month notice.

Insurance

Are you planning on using health insurance? □Yes □No If yes, please list:

Insurance company: _____

Group #: _____ Member #: _____

Employer or affiliation for coverage: _____

Relationship of client to insured: □ self □ spouse □ child □ other _____

Date of birth of insured: _____ Social security number: _____

Prior authorization # (if required): _____ co-pay (if known): ____

Is there an annual deductible? □Yes □No If yes, in what amount? _____

If I am not an in-network provider for your insurance company then I can provide a Superbill for you to submit when requesting reimbursement.

If there is an additional applicable insurance plan, please list that information on the back of this page.

Policy on Insurance

If you have insurance that provides coverage for mental health treatment, I can bill your insurance company for any pre-authorized sessions or I can help you process your insurance claim form for reimbursement.

It is important for you to know:

1. I will be required to provide basic information about you, your family, or your minor child (ren) including an assessment and the focus of treatment.
2. In order for therapy to be covered on your insurance, it has to be medically necessary. That means I will give you or the client a diagnosis which will become part of your/his/her medical record.
3. Not all therapy services are covered by all insurance companies. Some insurance companies predetermine which services they will and will not cover. For instance some policies do not cover family or couples counseling.
4. Your insurance company may require that you be pre-authorized for sessions.
5. It is your responsibility to be informed about, and comply, with the policies of your insurance company.
6. If your eligibility or that of the insured lapses for any reason you will be held financially responsible for any sessions provided during that time.
7. **You will also be held responsible for any sessions provided, that are not paid by your insurance company. This means your usual co-pay plus the portion that your insurance typically covers. This includes a non-emergency cancellation with less than 48 hours' notice.**

Please let me know if you have any questions or would like me to explain these policies further.

Statement of Understanding

I understand that I have a right to a copy of this agreement. **I have read, understand and agree to abide by these policies.**

_____ _____

Financially responsible person date

Carol Harvey MFT

204 G Street, Suite 205 Petaluma, CA 94952 | 707-765-2635

HIPAA NOTICE OF PRIVACY PRACTICES

Print a copy of this notice for your records only. You do not need to bring it to your first session.

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.
However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website. You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, carolharveymft.com

III. HOW I MAY USE AND DISCLOSE YOUR PHI.
I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. I can use your PHI within my practice to provide you with mental health treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

2. To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

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C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. **The Right to Request Restrictions on My Uses and Disclosures**. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that I that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before January 1, 2007.

I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete; (ii) not created by me; (iii) not allowed to be disclosed; or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me (Carol Harvey, M.F.T.) at (707)765-2635

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on January 1, 2007.

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Carol Harvey MFT
204 G Street, Suite 205 Petaluma, CA 94952 | 707-765-2635

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPAA PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at (707)765-2635 or visiting my website at www.carolharveymft.com

If you have any questions about my Notice of Privacy Practices, please contact me at: 204 G Street Suite 205, Petaluma, CA 94952.

I acknowledge receipt of the Notice of Privacy Practices of Carol Harvey, M.F.T.

_____	_____
Printed name of client	Printed name of client
_____	_____
Signature Date	Signature Date
_____	_____
Printed name of client, parent or guardian	Printed name of client, parent or guardian
_____	_____
Signature Date	Signature Date

Carol Harvey MFT
204 G Street, Suite 205 Petaluma, CA 94952 | 707-765-2635

Animal Assisted Therapy
Informed Consent and Release of Liability

I incorporate my dog, Millie into my psychotherapy work. I believe her presence benefits my clients & there are scientific studies to back me up. The use of animals by health professionals in their work is called animal assisted therapy. Numerous studies that show that interacting with animals helps people lower their blood pressure, increases engagement & reduces anxiety & depression. This consent form outlines the risks & rules needed to ensure your health & safety (as well as Millie's)as we work together.

Millie and I are currently in training with a professional therapy dog trainer. Millie still needs to learn some skills to pass her therapy dog certification test. First up will be the American Kennel Club's Canine Good Citizen test.

What you need to know:

1. You may opt to not have Millie in your sessions. Initial here if making that choice: _____
2. While Millie has been screened by a veterinarian before commencing work as a therapy animal, animals do sometimes carry disease. Because your contact is minimal, this risk is very small. Millie is up to date on all her vaccinations.
3. While Millie is a "hypoallergenic" dog (she has hair, not fur) there may still be a risk of an allergic reaction. Please let me know if you typically have allergies to animals.
4. If you or your child have a fear of dogs (however mild) then animal assisted therapy may not be appropriate for you. Let's discuss potential risks & benefits prior to the start of our work together.
5. As Millie's handler & as your therapist I will be looking out for your welfare as well as hers. However, it is important to remember that Millie is an animal & as such can be unpredictable. Millie is a gentle dog & affectionate dog, however, scratches, jumping, mouthing & unwanted kisses are all possible, especially during her early training.
6. Animals have individual rights, just as each client has rights. Millie gets to decide how & when she participates in the sessions. It is important for everyone's benefit (as well as safety) that she is not coerced or mistreated. She typically greets people enthusiastically & then sleeps.
7. Clients may not bring their own animal to also be involved in their therapy session. Let me know if you wish me to meet your animal, I can arrange for Millie to be elsewhere during that session.
8. Parents or guardians of children under the age of 10 must remain present during sessions.
9. Confidentiality is important to Millie. She won't talk about you, but it is possible she may recognize you outside of a session. Don't worry she is friendly with most people, so no one need know that she actually knows you.

While I have listed some common risks, I cannot foresee all potential risks. By signing this form you are stating your acceptance of the above rules & risks & agree to accept full liability in the event that Millie harms you or your child in any way in the course of treatment or as a result of treatment. By signing this form, you are releasing Carol Harvey MFT from any liability should any injury occur as part of your animal assisted therapy.

Statement of Understanding

I understand that I have a right to a copy of this agreement. I have had any questions, I may have had, answered to my satisfaction. **I have read, understand, & agree to abide by this agreement & consent to participate in animal assisted therapy with Carol Harvey MFT.**

client	date	client	date
client/parent/guardian	date	client/parent/guardian	date

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.