CLIENT'S CONSENT TO EXCHANGE INFORMATION/ ACKNOWLEGEMENTS/ SIGNATURES

PRIMARY CARE PHYSICIAN

Insurance plans and managed care organizations encourage the exchange of information between this office and your Primary Care Physician (PCP) in order to coordinate medical and psychiatric care. **Please make a selection below**.

☐ I give consent for information regarding my treatment to be shared with my PCP/Referring Physician/Pediatrician/Therapist as follows:

Name of PCP: _____ PCP Phone: _____

Located At: _____

Name of Therapist: _____ Therapist Phone: _____

☐ I do not wish to have information regarding my treatment with this practice released to my PCP.

INSURANCE CLAIMS PAYMENT I authorize the release of medical record information or excerpts thereof, to any insurance company or third party payor for utilization management, audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS I understand that I am financially responsible to pay Zoe Therapy Services (ZTS) its usual charges for all services received, including any balances not covered by my insurance carrier(s). I understand that it is the patient's responsibility to obtain any prior authorization or doctor's referral. I understand that failure to meet this requirement may result in a significant loss of benefits. I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to ZTS, and direct that payment of proceeds be made directly to ZTS. Because we reserve your appointment time for you, we charge a fee up to and including our full normal fee, for missed appointments not cancelled at least 24 hours in advance.

My signature below represents that I have read and understand the terms and statements above.

This consent and authorization form will remain in effect for the duration of my treatment unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this consent and authorization form is to be considered as valid as an original.

_____ _____

Patient's Signature Date Parent/Guardian's Signature Date

I have witnessed the completion of this authorization form. _____

Employee Signature Date

Acknowledgement of Notice of Privacy Practices

I understand I may request a copy of the Zoe Therapy Services Notice of Privacy Practices. I understand that I may ask questions to Zoe Therapy Services if I do not understand any information contained in the Notice of Privacy Practices.

_____

Patient/Guardian's Signature **Date**

Third Party Access

Access I authorize Zoe Therapy Services to disclose current healthcare information with the family/others listed below.

_____ _____

Spouse Parent

_____ _____

Sibling Other

_____ _____

Patient Signature Date Employee Signature Date

Contact Permission

If you would like to receive any correspondence through email, please write your email address

here _____

I, _____, hereby give permission for Zoe Therapy Services to contact me via phone, text or email.

If you would like to opt out of email correspondence, please check here _____