For Insurance

* *indicates a required field*

*** Client's name:**

*** Your relationship to client:**

- ○ Self
- ○ Parent/legal guardian
- ○ Personal representative
- ○ Other

*** I authorize Calm Gardens Therapy to:**

- ○ Send

*** I agree that Calm Gardens Therapy may send claims to my insurance(s) for processing to cover the cost of services I am receiving here.**

- ☐ I agree

You may opt to include any other additional information be released to your insurance. These additional items are not required to be released unless you select them.

- ☐ Medical history and evaluation(s)
- ☐ Mental health evaluations
- ☐ Developmental and/or social history
- ☐ Educational records
- ☐ Other

* In an instance where my insurance audits Calm Gardens Therapy, I am aware that they must send at least a Diagnosis, Progress Notes, Treatment Plans, and/or Discharge Notes. Moreover, I am aware that my signing of this Release indicates that I am okay with Calm Gardens Therapy sending these minimum required documents to your insurance.

- [ ] I am aware

This release of information authorizes the information described above to be sent to your insurance provider for either billing purposes (e.g., claims) OR for determination of eligibility for coverage should Calm Gardens Therapy or the client's medical records be audited by the insurance provider.

The above information may be used for the following purposes: Planning appropriate treatment or program; Continuing appropriate treatment or program; Determining eligibility for benefits or program; Case review; Updating files.

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

If I do not agree for this Release of Information to expire a year from the date of signing this document, the date this document is to be terminated is (MM/DD/YYYY):

* I am acknowledging my awareness that whether or not I choose not to complete this Release of Information, if my insurance or my insurance audits Calm Gardens Therapy OR otherwise reaches out requesting information that determines the coverage of my services with Calm Gardens Therapy, and I do not want my information sent to the insurance company, that I may be held responsible for the cost of services not covered by my insurance as a Self-Pay client.

- [ ] I agree

* Please select one of the options below regarding your acknowledgement of your ability to have any questions you have about this document be answered prior to signing. Please note that you may still ask questions after signing this document.

- [ ] I have had my questions answered prior to signing this document
- [ ] I did not have any questions about this document prior to signing

* Signature:

_____

I consent to sharing information provided here.

* Date:

Witness signature (if client is unable to sign):

Witness Date: