The Center for Integrative Psychotherapy
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In order to comply with specific rules regarding HIPAA (Health Insurance Portability & Accountability Act of 1996), we ask that our patients review and sign a privacy and security of health information document.

It is the office policy of the Center for Integrative Psychotherapy (CIP) and its staff to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voicemail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to indentify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

If you would like to have information released to someone other than yourself, please complete the following:

I authorize the Center for Integrative Psychotherapy and its staff to leave information pertaining to my care (appointments, billing, insurance, payments, etc...) by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone Number: (____)_____ Yes _____ No_____

Answering Machine at Home: Yes _____ No_____

Work Telephone Number: (____)_____ Yes _____ No_____

Voicemail at Work : Yes_____ No_____

Cell Phone and/or Voicemail number: (____)_____ Yes _____ No_____

Email Address: _____ Yes _____ No_____

Fax/mail authorization request/treatment plans for your insurance company: Yes___ No___

(OVER)

Which of the previous methods of communication is your preferred way of communication with the CIP?

- ❍ Home Telephone
- ❍ Work Telephone
- ❍ Cell Phone
- ❍ Email
- ❍ Other:_____

Please list the name(s) of authorized people to leave messages with and/or take messages from about your appointments (making, changing, canceling, etc...) insurance, payments and/or billing:

Spouse/Partner: _____ Yes _____ No_____

Parent: _____ Yes _____ No_____

Other Names (Please list relationship, such as boyfriend/girlfriend, father/mother, etc...)

1. _____ Yes _____ No_____

2. _____ Yes _____ No_____

3. _____ Yes _____ No_____

Patient Signature: _____

Parent/ guardian Signature: _____

(if under 18 years of age)

Date_____/_____/_____