Landmark Center for Behavioral Health

433 South Main Street
West Hartford, CT 06110
P:860-207-9449 F: 815-717-7564

AUTHORIZATION TO OBTAIN/RELEASE/ EXCHANGE *HEALTH TREATMENT INFORMATION*

I, _____hereby authorize Landmark Center for Behavioral Health to release to, receive from, or exchange with the names below (or you may decline and, write "NO".):

My Primary Care Physician (PCP) _____

Other Mental Health Provider(s) _____

Insurance Company/Managed Care Company

This authorization pertains to any portion of my medical record, including alcohol/drug treatment, and mental health information, and is intended to be used for insurance authorization, treatment planning, and follow-up care.

This authorization begins today and expires one (1) year from my last appointment with Landmark Center for Behavioral Health Inc. I understand I may revoke this authorization at any time by providing a written statement to the Office Manager *at the above office location*.

The information furnished is prohibited for any purpose other than that stated above AND the recipient is prohibited from disclosing this information to any other party, except as allowed or required by law or regulation. Therefore, information released by us may be subject to redisclosure and might no longer be protected.

A photocopy of this document has the same authorization as the original.

I understand if I have questions about disclosure of my health information, I can contact the Office Manager at the *above address or phone/fax numbers*.

Approve Appointment Reminder Calls/Text Messages/EMail: Yes or No: _____

These automated calls are generally made the day before your appointment, on Saturday for Monday appointments.

If YES, please use this email _____

If YES, please use this Phone # _____

Parent/Legal Guardian _____ *Date* _____

Patient Signature _____ *Date* _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is the "friendly" version.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

- Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which contains a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for handling of charts, patient records, PHI, and other documents or information.
- It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you may find valuable or informative.
- The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
- Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
- You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

Signature Date

LANDMARK CENTER FOR BEHAVIORAL HEALTH

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Date_____ Birthdate _____ Email Address_____

Name_____ Home Phone _____

Address _____ Cell Phone_____

City _____ State_____ Zip _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer _____ Business Phone_____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY INSURANCE

Subscriber _____

Relationship to Patient_____ Birth Date_____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State_____ Zip _____

Insurance Company _____

I.D. # _____ Group # _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Subscriber _____

Relationship to Patient_____ Birth Date_____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State_____ Zip _____

Insurance Company _____

I.D. # _____ Group # _____

ASSIGNMENT AND RELEASE

I Hereby authorize directly to Landmark Center for Behavioral Health for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____ Date _____

LANDMARK CENTER
FOR BEHAVIORAL HEALTH

Corporate Center West
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West Hartford, Connecticut 06110
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Financial Policy

As a patient of Landmark Center for Behavioral Health, your insurance coverage is verified to determine available benefits. Even though this information is reliable, it is not guaranteed. You are responsible for knowing the benefits, limitations, and/or restrictions that your individual policy may stipulate. This responsibility extends to understanding your pharmacy benefits.

We must emphasize that as medical providers, our relationship is with you. We file claims with your insurance company as participating providers but it is your responsibility to see that your charges are paid in full. Any deductions including copays, coinsurances, or non-covered services/supplies are expected at the time of service. Any unpaid balances are subject to service fees and possible referral to an outside collection agency.

Accounts unpaid are considered delinquent. Delinquent accounts will be referred to a collection agency or small claims court. All costs incurred for collections including finance charges, are the responsibility of the patient/parent.

I understand Landmark Center for Behavioral Health's financial policy and responsibility for my account.

_____ _____

Signature Date