Innovative Psychological Consultants

Release of Information Consent for Insurance: My signature below authorizes Innovative Psychological Consultants to exchange information with my current health insurance carrier in order to facilitate claims payment. I understand they will need to release my demographics, dates of service, diagnoses, and possibly my treatment plan and supporting information. I realize I can withdraw my consent at any time.

_____ _____
Client Signature (or Parent as Applicable) Date

Confidentiality Notice: My signature below indicates that I have read, received, and understand the limits of confidentiality for clients and healthcare providers in Minnesota.

_____ _____
Client Signature (or Parent as Applicable) Date

Informed Consent: My signature below indicates that I have been provided a copy of the *Informed Consent Agreement.* My signature below confirms my understanding of all the rules and responsibilities of both the client and the clinician. I have been informed and agree to adhere to the no show and late cancellation policy. My signature constitutes my agreement and compliance with the document.

_____ _____
Client Signature (or Parent as Applicable) Date

Federal Guidelines on Confidentiality:
Please indicate below whether you would like a copy of the Federal guidelines on confidentiality: Health Insurance Portability & Accountability Act (HIPAA)
____ Yes _____ No

Communication with Primary Care Physician:
Many clients, and insurers, like their clinician to communicate and share information with primary care physicians. Please indicate below if you would like us to contact and send a copy of your assessment to your physician.
____ Yes _____ No