New Client Information Donna M. Hunter, LCSW, CAP

Last Name:________________________________	Address: ____
First Name:________________________________	*Street* *City* *Zip*
Middle:___________________________________	Phone: ____________________hm/cell ________________________wk
DOB:_____________ SSN____________________	E-Mail:____

INSURED'S INFORMATION

Last Name:	First Name:	Middle:
SSN:	Address:	
Male Female / DOB:		
Insurance Plan Name:	Relationship to the Insured: Self Child Spouse	
Insured's ID#:	Phone:	
Group Policy #:	Employer:	

Assignment of Benefits and Release of Information

I hereby assign, transfer and set over to **Donna M. Hunter, LCSW, CAP/ Global Therapy, Inc**, all my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine benefits, including medical, surgical, psychiatric and/or substance (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments by my insurance Company.
I understand my signature requests that payment be made and authorizes release of my medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other Insurance company assigned cases, the Provider agrees to accept the charge determination of the Medicare/Other insurance company as the full charge, and the client is responsible only for the deductible coinsurance and non-covered cases. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other insurance company.

Signature__________________________________ date_______ Witness:____________________________________ date:______

INFORMED CONSENT FOR TREATMENT

I agree and consent to participate in behavioral health care services offered and provided at/by Donna M. Hunter, LCSW, SAP,CAP, a behavioral health provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license (Licensed Clinical Social Worker per the State of Florida (3309) and the State of Arkansas (2505-c), certification (Certified Addictions Professional, Substance Abuse Professional) and training (Hypnotherapy, Eye Movement Desensitization and Reprocessing); or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature____ Date_________________

Relationship to Patient (if applicable)____

Emergency Contact:____
NAME RELATIONSHIP PHONE NUMBER

Address: ____

Please Read: All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However**, the client is responsible for all fees, regardless of insurance coverage**. It is also customary to pay for services when rendered unless other arrangements have been made in advance. **Client Initials**______________

Behavioral Health Coordination with Health Care Practioner

Your Insurance Company would like your therapist to provide diagnoses, treatment plan, medication and prognosis information to your Primary Health Care practioner or Psychiatrist to help ensure that you receive comprehensive and quality health care and to assist in the management of your health care benefits. This information will not be released without your consent.

If the client does not provide complete contact information for the physician, this authorization will not be sent as requested.

I____, authorize Donna M. Hunter, LCSW, CAP for the purpose of continuity of care,
Printed name of client/guardian

to release the information below related to the evaluation and treatment of ____ to:
Client Name

Health Care Practioner:____ **Phone**:____________________________________

Address:____

I the undersigned understand that I may revoke this consent at any time to the extent that action has been undertaken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature unless another date is specified. I have read and understand the above information;

(   ) I give my consent to release the information to my Primary Care Physician or other health care practioners.

Date consent Expires;_____________________

(   ) I **DO NOT** give my consent to release the information to my Primary Care Physician or other health care practioner.

____ ____

Signature Client/ Guardian **Date** **Witness** **Date**

To any party receiving this information: This information has been disclosed to you from records which are protected by Federal and State Laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information with out specific written consent of the person to whom they pertain. Federal regulations under 42CFR Part 2 restrict any use of the confidential information to criminally investigate or prosecute any alcohol or drug abuse patients

If you are taking any medications please fill in the chart below

Medication	Dosage	Start Date	Prescribed By

To be completed by therapist:

Coordination of care with other treating professionals and the health care delivery system can be made with authorization if the client meets any of the following criteria:

__Is taking prescribed Psychotropic Medications

Current Diagnosis Axis I : _____________ Axis II______________

__Has reported a concurrent medical condition

__Has a substance abuse disorder

__Has a major mental illness (condition other than an adjustment disorder)

__Was referred by the PCP or other medical practioners

__ If the PCP will be following the client for psychotropic medications