STEVEN REISLER, PSY.D.

CLIENT NAME _____ **MARITAL STATUS** _____

DATE OF BIRTH _____ **MALE** ____ **FEMALE** ____ **SS#**_____

LOCATION: PRIVATE PRACTICE

PRIMARY INSURANCE _____

NAME OF COMPANY

_____

POLICY NUMBER (INCLUDING SUFFIX)

SECONDARY INSURANCE _____

NAME OF COMPANY (IF BC/BS - WHICH STATE)

_____

POLICY NUMBER

PROVIDER OF SERVICES ACCEPTS ASSIGNMENT. THE CLIENT WILL BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE (IE., $25.00 COPAYS).

CLIENT UNDERSTANDS HIS/HER RESPONSIBILITY: ☐ **YES** ☐ **NO**

FINANCIALLY ABLE TO MAKE CO-PAYMENT (IF ANY): ☐ **YES** ☐ **NO**

CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES AND ASSIGNMENT OF BENEFIT

I fully understand that I am giving my written consent to receive psychological services.

I agree that these services are mutually understood to be appropriate, and that I may withdraw my consent at any time.

I authorize **STEVEN REISLER, PSY.D.** to obtain and release information, regarding my treatment to any care provider/family member who presents a valid need for such information as determined by the provider.

I authorize release of medical information necessary to process claims for services rendered on my behalf. For these services I authorize payment directly to **STEVEN REISLER, PSY.D.** by Medicare, health insurance, or third party benefits.

Provider of services accepts assignment.

Kindly accept a photocopy or facsimile of this authorization as if it were an original authorization. I understand that my signature below will act as a signature on file.

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CONSENT TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

As a condition of providing treatment to you, **STEVEN REISLER, PSY.D.** may request your consent to use and disclose protected health information about you to carry out treatment, payment, and health care operations.

You may revoke this consent at any time by notifying **STEVEN REISLER, PSY.D.** *in writing*, except to the extent that the provider has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that **STEVEN REISLER, PSY.D.** may use of your protected health information. You have the right to review the Privacy Notice prior to signing this consent.

STEVEN REISLER, PSY.D. has reserved the right to change its privacy practices described in this Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice.

You have the right to request that **STEVEN REISLER, PSY.D.** restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. The provider is not required, however, to agree to such requested restrictions. If, however, the provider agrees to the requested restriction, the provider will honor the request and it will be binding.

I hereby consent to the use and disclosure by my provider, its workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

_____ _____

Signature of Client **Date**

_____

Print Client's Name