CLIENT INTAKE INFORMATION FOR PSYCHOTHERAPY SERVICES

CLIENT NAME:_____ DOB:_____

FACILITY:_____ MEDICARE#_____

GROUP THERAPY PROVIDER:_____

(Provider name is required only if group therapy services are indicated)

RELEASE AND CONSENT

I hereby consent to receive psychotherapy services and authorize Dr. John B. Houck to bill Medicare Part B or any other insurance carrier for those services rendered. I hereby release my medical/billing information so that Dr. John B. Houck can process these claims and agree to have those benefits paid directly to Dr. John B. Houck.

_____ Date:_____

Signature of Party Legally Responsible for Consent to Treatment (e.g. Power of Attorney, Guardian, or Client if they are their own Legal Guardian.)

Responsible Party did not sign but agrees to terms as specified above (witness signature required .)
Reason signature not obtained: []MS, []Paranois, [] Blindness, []Telephone Consent, []other_____

_____ Date:_____

Witness Signature

HIPAA SUMMARY NOTICE OF PRIVACY PRACTICES

I Acknowledge that I was offered the Notice of Privacy Practices as required by HIPAA.

_____ _____

Signature of Client Date

Client did not sign but received and understands the HIPAA Notice and agrees to the terms as specified above.
(Witness signature required.) Reason signature not obtained: []MS, []Paranoia, []Blindness,[]other_____

_____ _____

Witness Signature Date