



Making your life even better!

CLIENT INFORMATION

Client Name _____
Last First Middle

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell or Message Phone _____

Email _____

Where did you hear about us? _____

DOB ____/____/____ SSN____-____-____ Sex M F Marital Status _____

Parent/Guardian/Spouse _____ Phone _____

Primary Care Physician _____ Phone _____

Primary Insurance _____

Secondary Insurance _____

Policy # _____

Policy # _____

Group # _____

Group # _____

ID # _____

ID # _____

Effective Date _____

Effective Date _____

Subscriber SSN#____-____-____

Subscriber SSN#____-____-____

Subscriber DOB _____

Subscriber DOB _____



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CONSENT TO TREAT

To insure a fair and equitable payment plan for the patient and the office, full payment is due at the time of services.

** I hereby acknowledge and consent to treatment and/or evaluation for myself, my child, or legal ward as deemed appropriate. ** By signature, I acknowledge my intent to retain professional services from:

Serenity Life Coaches LLC
4650 S. National
Suite D-8
Springfield, Mo 65810
Phone: 417-886-2944

** I have been presented with a copy of **Serenity Life Coaches LLC's** "Notice of Privacy Practices" and acknowledge my understanding that any contractual agents who access my personal health information are "covered entities" under the Health Insurance portability and Accountability Act and will protect my privacy in keeping with said notice.

** The cost for services rendered will be \$100 per hour and due upon delivery of service unless previous arrangements have been made in advance in writing. We offer a sliding fee scale for clients in financial need. This range is from \$50-\$100 and based on financial need.

** I request that payment of Medicaid/Medicare or any Health Insurance benefits be made directly to **Serenity Life Coaches LLC** on my behalf for any services furnished to me. I authorize **Serenity Life Coaches LLC** to release any information needed about me to the insurance company, health care financing administration, and/or their agents to determine these benefits or the benefits payable for the related services.

** **Serenity Life Coaches LLC** does accept some but not all health insurance assignment. The patient is responsible only for the deductible, co-insurance and all non-covered services. **If insurance is billed, any "patient responsible" payments must be made upon receipt of bill.**

** I also agree to allow my records to be used for referral to another clinician/physician or state licensed representative for continuity of care.

** I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered. I have completely read this form and have completed it. I certify this information is true and correct to the best of my knowledge. I will notify the provider of any changes in my health insurance status or other information.

Patient/Parent/Guardian Signature

Date

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT COVER SHEET

Please have the client complete this cover sheet, and then tear off this cover sheet and file it in the client's medical record.

I, _____, hereby

acknowledge that I have reviewed this "Notice of Privacy Practices"

(containing a cover sheet and two pages of summary) with an effective date of January 1, 2011.

CLIENT SIGNATURE AND DATE _____ DATE _____

Copy of Notice of Privacy Practices received. _____ Initials

Copy of Notice of Privacy Practices denied. _____ Initials



AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize:

**Serenity Life Coaches LLC
Including those Mental Health Professionals Formally Affiliated with this Practice
4650 S. National Suite D-8 Springfield, MO. 65810**

to receive & disclose any and all information, tests, evaluations, reports, records, etc:

From: _____

In regard to: _____ DOB: _____ SSN: _____

For the purpose of: **Continuity of Care &/or Results, Treatment or Assessment**

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event this consent expires automatically as described below. I hereby release any person, firm, physician, clinic, hospital, or agency, public or private, from any liability for information furnished pursuant to this authorization.

THIS CONSENT EXPIRES TY ONE YEAR AFTER MY FINAL SESSION WITH THIS SERVICE AGENCY.

Executed this _____ day of _____, 2011

X _____
Signature of client (or legal parent/guardian or authorized representative if client is under 18 years of age or has been adjudicated legally incompetent).

Signature of witness: _____ Date _____

Please mail the information described above to address below.

Prohibition on re disclosure; this information has been disclosed to you from records whose confidentiality is protected by federal law, Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient.