CAROL CLIFTON, Ph.D.

INITIAL INTAKE SHEET
BUSINESS OFFICE FORM

NAME OF CLIENT:_________________________________DATE OF BIRTH___/___/___TODAY'S DATE___/___/___

ADDRESS:____CITY;_______________STATE_____ZIP:____________

HOME PHONE:(   )__________________________________MESSAGE PHONE:(   )_________________________

E-MAIL ADDRESS____

SPOUSE'S/PARENT'S NAME:____DATE OF BIRTH____/____/_____

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PERSON FINANCIALLY RESPONSIBLE:____

YOUR EMPLOYER:_______________________________________OCCUPATION:_____________________________

WORK PHONE:(   )______________ EXT:________CAN WE CALL AT WORK IF YOU ARE NOT AT HOME?_____

NAMES AND AGES OF CHILDREN:____

NEAREST RELATIVE NOT LIVING WITH YOU:____

ADDRESS:____

IN CASE WE NEED TO REACH YOU BUT ARE NOT ABLE TO, WHO SHOULD WE CALL?

NAME:____PHONE NUMBER:(   )_________________________________

WHO RECOMMENDED YOU TO CAROL CLIFTON, Ph.D.____

MAY WE SEND A THANK YOU NOTE FOR THE REFERRAL? YES________NO________

WERE YOU REFERRED FOR A PARTICULAR KIND OF THERAPY? YES______ NO______
IF SO, WHAT THERAPY?____

IF YOU HAVE INSURANCE THAT MAY POSSIBLY COVER YOUR COUNSELING, PLEASE FILL OUT THE BACK OF THIS SHEET. INDICATE IF THIS HAS BEEN DONE:___________________________

I HAVE READ THE ATTACHED FINANCIAL POLICY OF CAROL CLIFTON Ph.D. AND AGREE TO ABIDE BY IT.

______________________________________   **______/______/______**
SIGNATURE   **DATE**

INSURANCE INFORMATION

PRIMARY INSURANCE:_____

INSURED'S NAME:_____**RELATIONSHIP:**_____

INSURED ADDRESS:_____

NAME OF INSURANCE COMPANY:_____

ADDRESS AND TELEPHONE NUMBER:_____

_____

INSURED'S I.D. NUMBER:_____

PLAN OR GROUP NUMBER:_____

IS THERE A DEDUCTIBLE?_____

SECONDARY INSURANCE:

NAME OF INSURED:_____

RELATIONSHIP TO CLIENT:_____

INSURANCE COMPANY:_____

ADDRESS:_____

INSURED'S I.D. NUMBER:_____

IN ORDER TO FILE YOUR INSURANCE CLAIMS, THE NEXT PAGE MUST BE READ & SIGNED.

THANK YOU.

Dr. Carol Clifton Ph.D. 4/15/2003

CONSENT to Release Confidential Information for Insurance Purposes

Name:_____

Birth date:__/___/_____

I consent to the release of information from m confidential treatment record for treatment, payment, and healthcare operations. (See definitions below.)

I understand that, by law, I need not consent to the release of this information. This Consent for disclosure of information is not required for my treatment. However, I choose to do so willingly for the purposes specified above. I understand that I may revoke this Consent, in writing, at any time, except to the extent that action has been taken in reliance on my consent. Further, I understand that copies of all billings, reports or similar documents released to my insurance company or its agent shall also be available to me.

Please review the definitions below, and this practice's ***Notice Of Privacy Practices*** for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Signature_____Date:_____
Client, or parent or legal guardian of client

Definitions:
***Treatment** includes activities performed by this practice in providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care professionals. This consent includes treatment provided by any professional who covers this practice as an on-call professional.
****Payment** includes uses and disclosures required for determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and health plan management activities which may include review of your services for clinical necessity, justification of charges, pre certification and preauthorization.
*****Health Care Operations** includes the administrative and business functions of this practice

Changes in Privacy Practices:
Because we reserve the right to change our privacy practices in accordance with HIPAA Privacy Rules, the terms contained in the ***Notice of Privacy Practices*** may change also. A summary of the ***Notice of Privacy Practices*** will be posted in each professional office of this practice indicating the effective date of our current ***Notice of Privacy Practices*** in the upper right hand corner. We will offer you a copy of the ***Notice of Privacy Practices*** on your first visit to us after the effective date of the current ***Notice of Privacy Practices***. You will be given a copy of the ***Notice of Privacy Practice*** at your request. As more full explained in the ***Notice of Privacy Practices***, you may have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations. *We are not required to agree to your request.* If we agree, we are required to comply with your request unless the information is needed to provide emergency treatment to you. Other practitioners who may provide coverage for this practice are required to use and disclose your protected health information consistent with the ***Notice of Privacy Practices.***

I understand that I have the right to revoke this CONSENT provided that I do so in writing except to the extent that my therapist has already used or disclosed the information in reliance on this CONSENT.