PLEASE BRING COMPLETED FORMS WITH YOU TO YOUR FIRST APPOINTMENT

Sally King, MSW, LSCSW, LCSW 816-226-8211 www.sallykingconsulting.com
Licensed Clinical Social Worker-Missouri/Kansas sallykingconsulting@gmail.com

AUTHORIZATION FOR EVALUATION AND TREATMENT

I or my legal guardian, or health care surrogate, if any, hereby authorize Sally King to evaluate and treat, if necessary:

_____at_____

(Client's Name) **(Location of Therapy)**

This consent may be withdrawn at any time. Withdrawal of consent must be in writing to Sally King, LCSW. The client, legal guardian of health care surrogate, if any, has read and has had fully explained to him/her, and fully understands the above Authorization for Evaluation and Treatment. No guarantee or assurance has been made to the client or surrogate, if any, concerning the results, which may be obtained. I understand that a copy of the HIPAA Disclosure is on file with:

_____and that may review this at any time.

ASSIGNMENT OF BENEFITS

In order to submit a claim for payment to me for services covered under your policy, we must have your authorization to release medical information to your carrier. As a Medicare participation provider, Sally King, LCSW will accept assignment. According to Medicare guidelines, the provider will always accept the amount of Medicare's allowable, as charge owed by Medicare and Secondary insurance. The patient may be billed for Medicare deductible and co-insurance amounts in the event that there is not a secondary insurance or if the secondary insurance does not pay the Medicare deductible.

MEDICARE

I request the payment of authorized Medicare benefits to be made to Sally King, LCSW. I authorize any holder of Medical information to release to the health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to Sally King, LCSW any information regarding Medicare claims under the Title XVIII of the Social Security Act,

SUPPLEMENT INSURANCE

I hereby authorize the release of any information listed below that is necessary to file a claim with the insurance company and assign benefits to Sally King, LCSW.

_____

Signature of client, legal guardian or health care surrogate Date

_____

Printed name of client, legal guardian or health care surrogate

PRIMARY INSURANCE	SECONDARY INSURANCE
_____	_____
Company Name	**Company Name**
_____	_____
Street Address	**Street Address**
_____	_____
City, State ZIP	**City, State ZIP**

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Intro Face Sheet

Date:_____20___
Name: (last)_____(first)_____(m/i)_____
Account #:_____
SSN #:_____
Address:_____City_____
State_____ Zip_____

Home Phone: ( )_____Cell:( )_____
Gender (M)___ (F)____In case of Emergency_____

DOB:_____AGE:_____ Marital Status_____

Employment
status:_____
Employer:_____H
ealth Insurance company: Primary_____
Secondary_____

Referral source:_____
PCP contact info _____
Psychiatry contact:
_____
Residence situation:_____
Education level:_____
Religion:_____ Active?_____
Race:_____ Smoker?_____
Pets in home?_____ Weapons in home?_____
Other persons in the home?_____
Okay to leave confidential info on your voice mail? (yes)__(no)___

Notice of Privacy Practices

This notice describes how mental health therapy information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your mental health information may be used and disclosed by me. It also tells you how you can obtain access to this information

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy to this Notice.

I want to assure you that your mental health/health information is secure with me. It be locked up at all times and without your written permission, will not be discussed with any person. In order that your information remains private you are not required to sign a release of information form. However, should you wish to send your file to other professional s, or have Sally receive your files from other professionals, you will need to sign a Release of Information.

If you have any questions about this page, my name and contact info is provided below.

Effective Date of this Notice_____20__

Contact Person: **Sally D King**, MSW, LSCSW, LCSW. Phone 1-816-226-8211 or contact www.sallykingconsulting.com | sallykingconsulting@gmail.com

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have read this copy of Sally King NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified or change in any way."

_____

Signature Date

_____

Printed Name

[ ] Patient refused to Sign [ ] Patient was unable to sign because:_____

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Cancellation Policy

Effective March 1, 2013, there will be a cancellation policy that will apply to clients of Sally King. I will require 24-hour notice of cancelling an appointment unless it Is due to inclement weather. There will be a $30 fee for each no show or late cancelled appointment. After the third missed or no-show appointment, services will be terminated. If you have any questions or concerns, please discuss them with me. Thank you.

_____

Client Date

_____

Therapist Date