Mindful Treatments

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION
FOR
PRIMARY CARE PHYSICIAN

Physician Please Read
My name is _____ and I am providing psychotherapy to your patient. I am providing an ROI to inform you of their presenting concerns. Please utilize this information as you see fit in order to rule out any biological factors related to their psychological suffering. If you have any questions or would like to collaborate on their treatment feel free to call me at 804-648-0169.

Patient Please Read
It is important for your care to inform your physician of any psychological struggles you may be experiencing. Biological factors can often impact one's emotional/cognitive functioning and vice versa. By including your physician in your treatment it will make it more likely you experience improvement in your well-being. Please complete the form below if you will allow me to fax this form to your physician and to allow us to communicate in the future if needed.

I, _____, hereby authorize Mindful Treatments, LLC to obtain or disclose the following information:

[ ] I do not place any restrictions on the information provided, leaving this to the discretion of my therapist.
or
[ ] I request that the information be limited to the following:

[ ] Confirmation of participation in therapy
[ ] Treatment progress
[ ] Psychological testing results
[ ] Treatment summary
[ ] Summary of evaluation findings
[ ] Psychotherapy notes
[ ] Academic Records
[ ] On-going consultation
[ ] Medical Records and Lab Results
[ ] Other_____

Do not complete. Section filled out by psychologist.
Nature of Patient's presenting concerns: [ ] Anxiety; [ ] Depression; [ ] Eating Disorder; [ ] Self-Injury; [ ] Trauma; [ ] ADHD; [ ] Substance Abuse; [ ] Relationship Issues; [ ] Anger [ ] Other _____

I have been informed of the type of information being released; the benefits and disadvantages (if any); and I understand that treatment services are not contingent upon my decision concerning the signing of this release. I understand that my records are protected as confidential under state and federal law and cannot be disclosed without my written consent unless otherwise permitted in accordance with state and federal law and regulations. I understand that I may revoke this authorization at any time by notifying Mindful Treatments, LLC in writing. Should consent be revoked, I understand that doing so will not have any effect on information disclosed prior to the revocation.

This authorization shall remain in effect for one year unless noted. Alternative expiration date of this release: _____

_____ _____ _____
Physician Name or Organization | Phone | Fax

_____ _____
Signature of Patient | Date

_____ _____ _____
Signature of Parent, Legal Guardian or Authorized Representative of Patient | Relationship to Patient | Date

_____ _____
Witness | Date

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CONTACT INFORMATION FORM

Legal Name: _____ Preferred Name:_____

Preferred Pronouns:_____Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Please Circle: Employed Unemployed Full-Time Student Part-Time Student

Insurance Information

Policy Holder Name: _____Relationship to Subscriber:_____

Subscriber Date of Birth:_____ Employer of Policy Holder:_____

Group/Policy #: _____ ID number:_____

Policy Holder's Address (If Different):_____

Contact Telephone Numbers

Please complete relevant information and indicate the number at which you wish to be contacted first.

Primary		Phone Messages OK? Yes	No
☐	CELL: ( )_____	☐	☐
☐	HOME: ( )_____	☐	☐
☐	WORK: ( )_____	☐	☐

Email:_____

Circle preferred method of reminder(s) for upcoming appointments (can choose multiple):
None Email Text Call

Emergency Contact Information

In the case of an emergency, I allow Mindful Treatments, LLC to contact the following person for as long as I remain in treatment.

Name:_____Address:_____

Phone: ( ) _____ Relationship to you: _____

This may arise if we are concerned of your intent to harm yourself but we are unable to reach you or if there is a medical emergency in the office. The information released would be limited to the nature of the emergency.

How did you find out about this practice? _____

ACKNOWLEDGMENT AND AGREEMENT FORM

I have received and reviewed a copy of:

_____YES _____ NO HIPAA Privacy Policy

_____YES _____ NO Services Contract

By signing this form, I acknowledge that I have read, understand, and agree to all of the terms as outlined in the "Services Contract" document. I consent to participate in services at Mindful Treatments, LLC. I consent for Mindful Treatments, LLC to disclose necessary information to my insurance company in order to file claims and to charge past due statements to my credit card. I consent to allow Mindful Treatments, LLC to contact my emergency contact if the need arises. I understand that I may withdraw from treatment at any time without risk of adverse consequences.

Signature of Client_____ Date_____

Signature of Legal Guardian _____ Date _____

IF YOU DO NOT WANT YOUR INSURANCE FILED PLEASE INDICATE THIS BELOW.

I do NOT want my benefits assigned or my insurance filed. Therefore I am fully aware that I am responsible for ALL charges incurred.

Signature_____ Date_____