 Karen Ingalls, LPC

Open Door Counseling

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Opendoorcounselingpa.com

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AUTHORIZATION FOR RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS

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| --- | --- | --- | --- |
| Client Name: |  | Date of Birth: |  |

1. *Terms of Agreement*: I understand that by signing this agreement, I authorize my insurance company to reimburse Open Door Counseling for provision of services to me by Karen Ingalls, LPC.

2. *Medical Information Authorization*: I hereby authorize the use and disclosure of my health information to Open Door Counseling including any records pertaining to services rendered and/or treatment. I understand that this authorization is voluntary and I may revoke this authorization at any time by notifying Open Door Counseling in writing, but if I do, it won’t have any affect on any actions they took before they received the revocation.

3. *Assignment of Benefits*: I hereby authorize direct payment to Open Door Counseling of any insurance benefits for Karen Ingalls’ provided services. I also authorize my insurance company(ies) to furnish to Open Door Counseling any and all information pertaining to my insurance benefits and status of claims submitted by Open Door Counseling for services rendered. I further authorize Open Door Counseling to release to my insurance company(ies) any and all information pertaining to me for benefit determination.

4. *Financial Responsibility:* While there may be insurance coverage for those services provided by Open Door Counseling to me relative to my mental health needs, I recognize that services may not be entirely covered. I agree to be responsible for the charges which may not be covered by my insurance, particularly if my eligibility status changes. I understand that I am responsible for informing Open Door Counseling of any changes in my eligibility or of any additional insurance coverage.

5. *Permission for Disclosure and Use of Information*: I agree to the release of my Open Door Counseling mental health records to be reviewed by authorized representatives of my insurance or any future insurance coverage that I obtain for use in determining my mental health benefits.

I understand that this authorization is voluntary and I may revoke this permission at any time by notifying Open Door Counseling in writing, but if I do, it won’t have any affect on any actions they took before they received the revocation.

I understand that I have the legal right to refuse the release of my personal and mental health records now held by Open Door Counseling and that I am waiving this legal right by signing this consent. This consent shall be valid for whatever period of time is reasonably necessary for the individual/agency to review my records to determine my mental health benefits.

6. *Open Door Counseling Notice of Privacy Practices*: I have received, read and understand the Open Door Counseling Notice of Privacy Practices

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Client Signature Date