RIVER VALLEY BEHAVIORAL HEALTH & WELLNESS CENTER, LLC

Client Permission and Acknowledgement Form

Client Name: _____ **DOB:** _____

Assignment of Insurance Benefits

Private insurance companies and governmental insurance programs such as Medicare and Medicaid, require you to sign an assignment of benefits in order for us to bill your insurance company directly. Minnesota State Law requires a signed patient consent to release medical information to your insurance company and any other parties cooperating in the delivery of your care.

By Signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance of my prior consent. I understand that if I revoke this authorization, I will need to pay for services out of pocket. This consent is given freely with the understanding that:

1. Any and all records, whether written, oral or electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except for otherwise provided by law.
2. Information used or disclosed pursuant to this authorization may be subject to re-disclosure and is no longer protected.
3. A photocopy or fax of this consent is as valid as the original.

I understand that copays are due at the time of service and that deductibles, coinsurance and charges not covered by my insurance company are due within 30 days of insurance processing.

Client/Guardian Signature: _____ Date: _____

Notice of Privacy Practice

I acknowledge that I have received/been offered a copy of HIPAA notice of privacy practice.

Client/Guardian Signature: _____ Date: _____

Authorization for Client Information to be Disclosed

While I am a client at River Valley Behavioral Health and Wellness Center, or until this permission is revoked through written request, I hereby authorize _____ Relationship to client _____
(name of designated person)

☐ To make or check on appointments

☐ To have access to financial information

Client/Guardian signature: _____ Date: _____

Emails and Text

At your request, we can sign you up for our client portal, however it is important that you understand that the internet is not a secure delivery system**. Please initial your selections**.

☐ Please sign me up for the patient portal. ☐ Please sign me up for RVBHWC Newsletter.

Email address: _____

TEXT REMINDER: If you originally opted for text appointment reminders, **THIS IS A COURTESY REMINDER AND IS NOT GUARANTEED!** Do not use confirm feature. Cannot cancel appointments through text. If you need to cancel your appointment call within 24 hours (this excludes Sundays and holidays).

Insurance update: Y N ☐ ☐ **Address update: Y N** ☐ ☐ New Address: _____

(If yes, call: 952-746-7664 to update)