Strength of Mind

Patient

Name:	DOB:	SSN:	Sex:
Address:	Primary Phone: ☐ Cell ☐ Home	Alternate Phone: ☐ Cell ☐ Home	
City:	State: Zip:	Marital Status:	Preferred Pharmacy and Address:
Email Address:			
Preferred Language:	Pat. Height	Pat. Weight	Preferred Number for Appointment Reminders: Call (_____)_____ - _____

Emergency Contact Information

Name:	Relationship:	Phone:

Responsible Party (Parent or Legal Guardian)

☐ Same As Patient	Name:		Relation to Patient:	
DOB:	SSN:	Marital Status:	Sex:	Phone:
Address:	City, State, Zip:			

Insured Party (Insurance Card Holder)

☐ Same as Patient ☐ Same as Parent/LG	Name:	Marital Status:	Sex:
DOB:	SSN:	Employer Name and Address:	
Address:	City:	State:	Zip:

Authorization to Release Information and Assignment of Benefits

I hereby certify that the information I have reported with regard to my insurance coverage is correct. I authorize Strength of Mind to apply for insurance benefits on my behalf for covered services rendered by Strength of Mind. I also authorize the release of any medical information necessary to process all insurance claims. I request the payment from my insurance company be made directly to Strength of Mind or Dr. Clayton Rogers. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

In addition to the releases outlined above, information may be released to the following individuals or organizations for the indicated purpose:

By signing below, I state that I have read and understand all Strength of Mind's office policy statements and I have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Name of patient (please print):_____

Signature: _____ Date: _____

(Patient, Parent, or Legal Guardian)

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, Strength of Mind originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

→ a basis for planning my care and treatment

→ a means of communication among the healthcare professionals who contribute to my care

→ a source of information for applying my diagnosis and treatment information to my bill

→ a means for a third-party payer to verify that services were billed as actually provided

→ and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that, Strength of Mind, reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Strength of Mind is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you ….**that the information authorized for release may include records which may indicate the presence of a communicable, noncommunicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

Treatment of a minor

Parents legally have rights to all information their children share in therapy. However, Strength of Mind makes it a practice to keep what is shared private unless it deals with unsafe or illegal behavior. Strength of Mind will not withhold information from either parent unless the proper legal documentation stating a parent's rights have been terminated is provided.