

Patience D. Stevenson, D.Min., LMFT, LPC, NCC
1754 West Broad Street, Bethlehem, Pa. 18018

Client Communication Permission

Patient name: _____ SSN: _____
DOB: _____

As a client in my practice, from time to time I may need to communicate with you when you are not in the practice. To preserve your privacy, I would like you to indicate your preferred method for me to communicate information to you.

Without specific permission I will not release any of your medical or billing information to another person. In some cases you may wish for another person to have access to your medical information.

In the event that no one is available to answer your phone, I need permission to leave certain types of information on your answering machine or with another person. Please indicate **your preference** by checking one or more of the items below.

Do not leave medical information on an answering machine or with another person.

I give permission for Patience D. Stevenson to leave any and all medical information pertaining to me, including appointment reminders, on my home answering machine at the number listed below:

Phone Number: _____

I give my permission to Patience Stevenson to give any and all medical information pertaining to me, including appointment reminders to the individual listed below:

Name: _____(i.e. family members who might answer the home phone)

I give my permission for Patience D. Stevenson to discuss my account balance, insurance coverage/benefits, payment plans, payments and history of my account to the individual listed below:

Name: _____(i.e. Insurance Co.)

Patient Signature

Date

Witness

Date

COMBINED ACKNOWLEDGMENT AND CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND
CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgment and Consent

This acknowledgement of notice and consent authorizes Patience D. Stevenson, D.Min., to use and disclose health information about you for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices. Patience D. Stevenson, D.Min. has a Notice of Privacy Practices, which describes how I may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review my current notice prior to signing this acknowledgement and consent.

Amendments. I reserve the right to change my Notice of Privacy Practices and to make the terms of any change effective for all protected health information that I maintain, including information obtained prior to the date of the effective date of the change. You may obtain a revised noticed by submitting a written request to me, as the Privacy Officer:

How to contact Privacy Officer:

Patience D. Stevenson, D.Min.
1754 West Broad Street
Bethlehem, Pa. 18018
610-866-6647(O)

Acknowledgement and Consent

Print or type all information except signature.

I have received the Notice of Privacy Practices for Patience D. Stevenson, D.Min., and authorize her to use and disclose health information about me, _____ (patient name) for treatment, payment, and healthcare operations purposes consistent with my Notice of Privacy Practices.

Signature of Client (or personal representative)

Date

Name of personal Representative

Relationship to client