Capitola Counseling

Confidentiality agreement and duty to warn

Confidentiality and privileged communication remain rights of all clients of behavioral practitioners according to the law, some courts have held that if an individual intends to take harmful acts or dangerous action against themselves, or another human being it is the practitioners duty to warn the person or the family of the person or the family of the person the client intends to harm his/her self or such an intention is taking place.
I as a behavioral therapist, will under no circumstances inform such individuals without first sharing intention to do so with you my client, unless it is not possible to do so. Every effort will be made to resolve the issue before such a breach of confidentiality takes place.

_____
Therapist Elizabeth Kovacevich Lic# MFT9137

I have read the above statement and understand the therapist's social and legal Responsibility to make such decisions when necessary.

_____ _____
Name Today's date

_____
Signature

Capitola Counseling

Release of Information

I authorize Elizabeth Kovacevich to contact my primary care physician (name) _____or _____
from_____
regarding an appointment being made for a follow up, as well as information pertaining to my emotional well being and
psychological function.

Name_____date_____

Signature_____

Capitola Counseling

INSURANCE BILLING FORM (PRIMARY)

Name of Primary Insurance Company:_____

Insured's Name:_____
Last Name First Name Middle

Insured's Address (if different from patient's):_____

City:_____ State:_____ Zip:_____

Home Phone:_____

Sex: M / F Birth Date:_____

Age:_____

Insured's ID Number:_____ Social Security Number:_____

Insured's Policy, Group, or FECA Number_____

Insured's Employer's Name:_____

Insurance Plan Name or Program Name:_____

Insurance Effective Date:_____

Patient's Relationship to Insured (circle one): Self Spouse Child Other

(Specify)_____

Patient's Status (circle all that apply): Single Married Other (Specify)_____

Employed Full Time Student Part Time Student

Is Patient's Condition related to:

Current or Previous Employment? YES / NO

Auto Accident? YES / NO If yes, give state_____

Other Accident YES / NO If yes, please give details.

SIGNATURE REQUIRED BELOW:

ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment of all medical benefits for services rendered directly to Elizabeth Kovacevich, MFT.

RELEASE OF INFORMATION TO THIRD PARTY PAYER: I hereby authorize Elizabeth Kovacevich, MFT to release any information regarding history, physical or mental condition, consultation, treatment or psychotherapy rendered, including a copy of her records, concerning all claims to third parties responsible for payment of all or part of the charges.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: (A photocopy of this form and my signature will be considered as valid as the original).

_____ _____

Signature of Patient or Insured Date

****** Please Include a Copy of the Front and Back of all Insurance Cards *****