KRISTEN J. FLYNN, LCPC

333 Lincoln Street, Saco, Maine 04072 - (207) 228-4596

CLIENT REGISTRATION FORM

Today's Date:						
CLIENT INFORMATION						
Client's last name:	First:	Middle:	Date of Birth:	Age:	Gender: T	
					M	F

Marital Status:	Home Phone:	Cell Phone:
Single Married Life Partner Divorced Separated Widowed		

Street address:	City:	State:	ZIP Code:

Person responsible for bill (if a minor):	

Social Security:	Employer:	Employer phone:

Referred By:	PCP.		Family	Friend	Insurance Plan	Other:	

Current Medications:	
PCP:	
Psychiatrist:	

INSURANCE INFORMATION
(PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD FRONT AND BACK)

Name of Primary Insurance:	Primary Insurance Phone:

Subscriber's name:	Subscriber's SS#:	Birth date:	Subscriber ID#:	Group#:

Client's relationship to subscriber:	Self	Spouse	Child	Other	

Name of Secondary Insurance (if applicable)	Secondary Insurance Phone:

Subscriber's name:	Subscriber's SS#:	Birth date:	Subscriber ID#:	Group#:

Client's relationship to subscriber:	Self	Spouse	Child	Other	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to Client:	Home phone:	Work phone:

I authorize the release of any medical/mental health information necessary to process my insurance claims. I authorize payment of health benefits to Kristen J. Flynn, LCPC for services rendered. I have read or completed this form fully and completely, and certify I am the client or duly authorized general agent of the client authorized to furnish the information requested. I understand I am responsible for payment of any deductible and co-payment/coinsurance as determined by my insurance carrier. If I need to cancel or change an appointment, I will provide at least 24-hour notice prior to the appointment in order to avoid a charge for the missed appointment or late cancellation. {Please note that insurance companies will not cover missed or no-show appointments}. I will be fully responsible for this charge if I do not give the proper 24-hour notification.

X	
Client/Guardian signature:	Date

Internal Use Only

DX Codes:		CPT Codes:		Place of Service:	Home
					Office

CONSENT TO USE OR DISCLOSE CLINICAL INFORMATION

I authorize Kristen J. Flynn, L.C.P.C. to use and disclose the health and clinical information of ______________________ for the purposes of Treatment*, Payment** and Health Care Operations***.

***Treatment** (includes activities performed by Kristen Flynn, providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care professionals. This consent includes treatment provided by any professional who covers this practice as an on-call professional).

****Payment** (includes uses and disclosures required for determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and health plan management activities which may include review of your services for clinical necessity, justification of charges, pre-certification and pre-authorization).

*****Health Care Operations** (includes the administrative and business functions of this practice).

You should review Kristen J. Flynn's ***Notice of Privacy Practices*** for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT.

Because I reserve the right to change my privacy practices in accordance with the HIPAA Privacy Rules, the terms contained in the ***Notice of Privacy Practices*** may change also. I will offer you a copy of the ***Notice of Privacy Practices*** on your first visit to me after the effective date of the current ***Notice of Privacy Practices****.* You will be given a copy of the ***Notice of Privacy Practices*** at your request.

As more fully explained in the ***Notice of Privacy Practices****,* you may have the right to request restrictions on how I use and disclose your protected health information for treatment, payment, and health care operations. *I am not required to agree to your request.* If I agree, I am required to comply with your request unless the information is needed to provide emergency treatment to you. Other practitioners who provide coverage for this practice are required to use and disclose your protected health information consistent with the ***Notice of Privacy Practices****.*

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Kristen J. Flynn, L.C.P.C. has already used or disclosed the information in reliance on this CONSENT.

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:__________________________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Kristen J. Flynn's, LCPC Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Kristen Flynn at 207-228-4596.

____

Signature of Patient/Client **Date**

____

Signature or Parent, Guardian or Personal Representative * **Date**

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* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

- ❑ **Patient/Client Refuses to Acknowledge Receipt**:

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