LAURIE SCHMIT, In the Heart Counseling, PLLC
Mailing: PO Box 2023, Grand Rapids, MI 49501-2023
Office: 233 Fulton E, Ste. 226, Grand Rapids, MI 49503
ph: 616.426.9226 | **fax:** 616.825.5980
e-mail: LSchmitLMSW@gmail.com

Insurance Permission Form

Welcome! Please complete this form for insurance purposes. Thank you!

Client's Full Legal Name: _____Date of Birth (DOB): _____

Who is completing this form? ____ Self / Other: _____
(Name & Relationship to Client)

Client's Residence: _____

- OK to send mail to the above address? Yes No *(circle one)* Mail Address:_____

Client's Primary Phone: (_____)_____ *(circle one):* Cell Home Work

- OK to leave voicemail? Yes No *(circle one)* OK to text? Yes No *(circle one)*

Client's Secondary Phone: (_____)_____ *(circle one):* Cell Home Work

- OK to leave voicemail? Yes No *(circle one)* OK to text? Yes No *(circle one)*

Client's Email Address: _____

- OK to communicate through email? Yes No *(circle one)*

Primary Insurance ID or Contract#_____ Group #_____

Name of Insurance: _____

Subscriber *(who holds the policy):* _____ Subscriber's DOB: _____

Subscriber's Address: _____

PO Box for claims *(on the back of the card):* _____

Secondary Insurance ID or Contract#_____ Group #_____

Name of Secondary Insurance: _____

Subscriber *(who holds the policy):* _____ Subscriber's DOB: _____

Subscriber's Address: _____

PO Box for claims *(on the back of the card):* _____

_____I agree that staff of The Collaborative Center are hereby authorized to submit insurance claims and follow up on insurance payments on behalf of Laurie Schmit, LMSW.

Client, Parent or Legal Guardian Signature: _____ Date: _____

Signature of Treating Provider: _____

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HIPAA and Privacy Practice Acknowledgement

I have had the opportunity to read the Notice of Privacy Practices. I understand that my health information is private but there is some health information that may be shared with other entities under special circumstances. I understand I will be required to sign an authorization to release or request medical information from any entity. I understand I have rights to health information regarding my care. I have had the opportunity to have my questions answered.

_____ _____
Client Name (please print) Date

_____
Client Signature / Signature of Parent or Legal Guardian

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Authorization for the Release or Request of Medical Records and/or Health Information:

Primary Care Physician Or Psychiatrist

The purpose of this authorization is to allow the release, request or exchange of medical records and verbal or written information with your Primary Care Physician or Psychiatrist.

Client: _____ DOB _____

_____ I **do not wish** to authorize communication or record exchange between my therapist and my Primary Care Physician/Psychiatrist at this time.

OR

_____ I authorize the release of my medical records, including verbal or written information, to my Primary Care Physician's/Psychiatrist's office.

_____ I authorize the request of my medical records, including verbal or written information, from my Primary Care Physician's/Psychiatrist's office.

Primary Care Physician/Psychiatrist:

_____

Address: _____

Phone Number: _____ Fax Number: _____

_____ I authorize the release or request of my medical records, including verbal or written information, for Coordination of Care.

Do you want to withhold or exclude any information? _____ Yes _____ No

If yes, please list information to be withheld: _____

The dates covering this request include _____ to _____
(DATE BEGAN CARE WITH PCP) *(one year from today's date)*

This form will expire one year from today's date or when counseling services are closed, whichever occurrence happens first.

_____
Client, Parent or Legal Guardian Signature Date

_____
Witness Signature

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy of health information and persons/organizations receiving this information. Re-disclosure of medical records or information released under this agreement is prohibited by the Michigan Mental Health Code (sections 748, 749, and 750 of the Public Act 258 of 1978) and by Title 42 of the Code of Federal Regulations, Part II, and this authorization is compliant. I understand that certain healthcare information may be protected under State and Federal Law (42 CFR Part 2 and RCW 70.24). I reserve the right to revoke this consent at any time prior to its expiration, except to the extent that the facility which is to release information has already taken action in accordance with it. I agree that medical records or information may be faxed for expediency. I have a right to request a copy of the information disclosed. Federal law permits a fee to be charged for the copying of medical records and you may be required to pay for the copies. *I understand that it takes time for the office to locate and send medical records or information and will allow up to 10 business days for the office to process my request to release or request medical records or information. By signing this authorization you are agreeing that you have the legal capacity to sign this agreement, and to the release or request of medical records or information and its benefits and consequences, and have had the opportunity to have had questions answered and this form explained. By signing as a witness, you are not the requestor of records, and you are agreeing you physically watched the patient, parent or legal guardian sign this authorization, and attest to their capacity to do so.*

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CLIENT'S NAME: _____

SELF-PAY AGREEMENT

There are scenarios in which a provider must bill for services directly to the client, parent, or legal guardian. The purpose of this form is to educate the cost of services when choosing or effected by the following scenarios:

-The client has insurance coverage but is choosing not to utilize it.

-The client has insurance coverage but the provider is out of network. (There are some insurance companies that have "out of network" benefits).

available. We can always attempt to bill to see what they cover.

-The client has insurance coverage but has exhausted/met their benefits for the year.

Insurance Plan: _____

Benefit explanation: _____

-The client does not have insurance coverage.

The amount due for the initial evaluation is: _____

The amount due for a traditional follow up is: _____

If unique circumstances arise throughout treatment, costs may vary slightly from the above listed. Examples include family therapy, relationship counseling, and extended counseling sessions. Fees are available upon request.

I have had the opportunity to have this form explained to me and had my questions answered. I agree with the terms outlined in the form and agree to pay for services rendered by my therapist.

Patient's Name (Please print): _____ Date: _____

Patient or Parent/Legal Guardian's Signature: _____

Witness Signature (Staff Signature): _____

Therapist's Name: _____

Client and/or legal guardian obtained a copy of this form: (circle one)

YES

NO

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CLIENT'S NAME: _____

AUTOPAY AGREEMENT FORM

FOR BILLING/ADMINISTRATIVE OFFICE USE ONLY
Client's current insurance provider: _____
Client's current copay / coinsurance amount: $_____
Notes:

Client's Name (Please PRINT Name): _____ DOB: _____

Who is filling out this form? _____ Relationship to client: _____

1. I agree to allow Laurie Schmit, LMSW to maintain my authorized payment form in my Confidential and HIPAA Protected Electronic Medical Records Chart managed by TherapyNotes™.

2. Laurie Schmit, LMSW may use provided payment method for (check each that applies):

   ____ a one time payment in the amount of: $_____
   ____ auto payment for co-pay/co-insurance/self-pay per visit in the amount of: $_____
   ____ co-pay/co-insurance/self-pay on an agreed upon recurring date.
   Recurring date to run card: _____ Recurring amount to charge on card: _____

3. To change or revoke this agreement at any time, please contact Laurie at: 616-426-9226; fax: 616.825.5980, or email: Lschmitlmsw@gmail.com.

4. Payment method will remain active until revoked, payment method expires, or client file is permanently closed/terminated.

Card Holder's Name: _____

Card Number: _____

Exp Date: _____ CVV: _____

Billing address for this card:_____
(STREET ADDRESS)

_____ Revoke Date:_____
(CITY) (STATE) (ZIP)

_____ _____
Client/Card holder signature ***Date***

_____ _____
Witness Signature ***Date***