Ellen Savage - Amalia PC Licensed Clinical Professional counselor #27
PO Box 395 Chinook MT 59523 406-262-4242

HIPAA

_____I/We authorize use of the form on all my insurance submissions.

_____I/We authorize release of information regarding billing to all my insurance companies.

_____I/We understand that I am responsible for my bill.

_____I/We authorize my doctor/provider and billing company (Back Office Solutions, LLC)to act as my agent in helping me obtain payment from my insurance companies.

_____I/We authorize payment direct to doctor/provider when billing is not sent by yourself.

_____I/We permit a copy of this authorization to be used in place of the original.

_____I/We have reviewed a copy of HIPAA standards for this office.

Do we have your permission to call your phone and leave a message?

***Home phone Yes____ No____**

Cell phone Yes____ No ____

Work phone Yes____ No ____

Regarding appointments? Yes _____ No_____

Regarding account information? Yes_____ No_____

Name(s) _____/_____

Signature(s)_____/_____

Date _____/_____/20_____

PLEASE NOTE! IF YOU ARE BEING SEEN IN THIS OFFICE FOR AN INITIAL VISIT AS A COUPLE, BOTH OF YOU MUST SIGN THESE FORMS. THANK YOU.