REFLECTIONS
HEALTH & WELLNESS

Authorization for Psychological Services and Billing

Client Name: _____ Location: _____ Date:_____

By signing below, you are allowing a psychologist or licensed independent social worker from Lewis and Evans, LLC dba Reflections Health & Wellness (aka "Reflections H&W") to provide mental health services to you. A psychological assessment will be done, and treatment may be recommended. By signing this authorization, you agree to accept and participate in professional services with the Reflections provider. Should you at any time decide that you no longer wish to receive mental health services you may stop treatment.

Reflections H&W will bill the cost of services to your health insurance carrier. By signing, you agree to allow us to bill your health insurance carrier for our services, and you give Reflections H&W permission to bill your health insurance carrier. You also give Reflections H&W permission to provide information to your health insurance carrier needed to determine your benefits, and you give Reflections H&W permission to release any information necessary to bill your health insurance carrier for any services provided to you. Health insurance carriers include Medicare, Medicaid, and/or any other insurance or managed care benefits you may have. You are authorizing any holder of medical information about you to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. Further, by signing this authorization you additionally agree to pay for any charges not covered by your insurance. This authorization will remain in effect until you revoke it.

By signing below, you are approving our contact with your primary physician, family members, and appropriate facility staff, and/or their designated agents. By signing you are also approving our contact with authorized billing and claims processing entities, as permitted under HIPAA and other federal and state laws, for the purpose of collecting the allowed fees from your insurance carrier.

As a condition of providing treatment to you, the provider herein requests your consent to use and disclose protected health information about you to carry out treatment, payment, and health care operations. By signing below, you are consenting to the use and disclosure by your provider, its workforce, and its business associates of your protected health information for purposes of treatment, payment, and health care operations.

You understand and agree that your disclosures and communications are considered privileged and confidential except to the extent that you authorize a release of information or under certain other conditions as prescribed by law. You understand that confidential and privileged information may be released without your consent or authorization under circumstances recognized by Ohio law and HIPPA.

Should you have any questions, please call Reflections Health & Wellness at 614-792-1108.

SIGNATURE: _____ **WITNESS:** _____

Relationship to resident: ☐Self ☐ Guardian

- ❑ Patient gave verbal consent/ unable to sign
- ❑ Patient assisted in giving signature
- ❑ Patient refused services

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