The Self-Care Path, LLC
1333 Burr Ridge Parkway, Suite 200
Burr Ridge, Illinois 60527
Phone: 708-429-0353
Fax: 386-263-8326
www.selfcarepath.com

Consent to Health Care Operations Form

By signing this document, you release your provider to disclose the information necessary to bill for services (in-person services and telehealth/telemental Health services) and for the purposes of operating a counseling business/service.

Your provider is a member of a Limited Liability Company, and includes: professional counselors, an office administrator, and our billing software: TheraNest. All members and contractors are required by law to adhere to HIPAA Law.

Definition: "My protected health information" includes health information (regarding a mental or physical condition), that is past/present/future, collected from me and created/received by my provider, and it identifies me. This also includes my demographics, health plan, and employer.

I consent to my provider using or disclosing my protected health information (diagnoses and treatment) for the purpose of obtaining payment for my health care bills or to conduct healthcare operations. Other disclosures require a separate Release of Information.

Also, I understand that diagnoses and treatments of me by my provider are provided upon my consent as evidenced by my signature on this document. *For individuals between 12 and 17 years old, parental consent is required following the 5th appointment. This means that individuals between 12 and 17 years old may receive services without parental consent of a parent for the first 5 appointments.*

I also understand that while all therapists and office administrative professionals have access to my client file for business and billing purposes, no one has permission to look at my assessment, progress notes, treatment plan, or case file; nor can anyone at The Self-Care Path, LLC discuss my case unless I have signed a Release of Information.

I understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. My provider is not required to agree to the restrictions that I may request. However, if my provider agrees to the restriction that I request, the restriction is binding for my provider.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This Notice of Privacy Practices also describes my rights and the duties my provider with respect to my protected health care information. My provider reserves the right to change the privacy practices that are described in the notice. I may obtain a record of a revised notice of privacy practices by requesting it. My provider will always notify patients of changes if they occur. Or, I know I can visit this webpage in order to obtain information about HIPAA Law as it relates to mental health: http://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html

I understand I have a right to review the Notice of Privacy Practices prior to signing this document and that the webpage for the Notice of Privacy Practices has been provided to me.

I have the right to revoke this consent, in writing, at any time, except to the extent that my provider has taken action and reliance on this consent.

Please Verify: ☐ I understand this consent form, and my provider has clarified any questions about this form.

Signature____ Date: ________________
(of patient, or guardian when under 12yo)

Printed Name: ____