

CLIENT REFERRAL FORM

Today's Date:								
CLIENT INFORMATION								
Client's last name:			First:		Middle:	Date of Birth:	Age:	Gender:
								<input type="checkbox"/> M <input type="checkbox"/> F
Marital Status:					Home Phone:		Cell Phone:	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Life Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed								
Street address:					City:		State:	ZIP Code:
Person responsible for bill (if a minor):								
Social Security:			Employer:			Employer phone:		
Referred By:	<input type="checkbox"/> PCP.				<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Other:
Referral name and contact information								
INSURANCE INFORMATION								
Name of Primary Insurance:						Primary Insurance Phone:		
Subscriber's name:			Subscriber's SS#:		Birth date:	Subscriber ID#:		Group#:
Client's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
REFERRAL CONCERNS								
FAX TO (207) 221-1496								

CONSENT TO USE OR DISCLOSE CLINICAL INFORMATION

I authorize Karla Diffin, Ph.D., 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 Karla Diffin, 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 Karla Diffin'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 we reserve the right to change our privacy practices in accordance with the HIPAA Privacy Rules, the terms contained in the **Notice of Privacy Practices** may change also. We will offer you a copy of the **Notice of Privacy Practices** on your first visit to us 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 we use and disclose your protected health information for treatment, payment, and health care operations. *We are not required to agree to your request.* If we agree, we are 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**.

Please verify that you have received a copy of our **Notice of Privacy Practices** by signing your initials here_____.

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

Signature of Client _____ **Date** _____
Signature of Legal Guardian or Representative _____ **Date** _____

Please indicate below the nature of your relationship to the client:
