Live Free Therapy, LLC
433 Meadow Street
Fairfield, CT 06824

Demographic Information, Consent Form and Billing Form

First Name Last Name Middle Initial

Street Address City State Zip Code

Client's Date of Birth Phone Number Email Address

I acknowledge that I read a copy of Live Free Therapy's Notice of Privacy Practices (which includes our previous Covid-10 policies) and I am aware of HIPAA policies and regulations. Upon request, I can receive a copy of Live Free Therapy's Notice of Privacy Policies.

Signature Date

If you are signing as a personal representative of the patient, describe your relationship to the client and the source of your authority to sign this form:

Name Relationship to Client

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Insurance / Billing

If we do not accept your insurance, upon request, we will email you a superbill/ receipt for you to submit to your insurance company. Please complete below information for us to help you further:

Insurance company:____

Member ID: ____

Group Number: ____

Policy Holder's Name: ____

Policy holder's date of birth: ____

Policy holder's phone number: ____

Policy holder's address: ____

Please note: Insurance companies ask for information from us that helps them determine the need for coverage, amount of coverage, and continuation of coverage. If you intend to submit claims to your insurance company, your carrier may contact us by phone, fax, or mail for information such as age, date of birth, spelling of names, verification of address and telephone numbers, or treatment compliance. They may also wish to discuss, review, or confirm information such as diagnosis codes, procedure codes, dates of service, and type of therapy (i.e., individual counseling, psychodynamic counseling, EMDR, etc). No confidential descriptive, narrative, or representational information will be discussed without a separate, signed authorization from the client. Corresponding with your insurance company is not an indication that Live Free Therapy, LLC will accept payment for services from your insurance company. To authorize this type of communication, please sign and date below.

Having read this form and the above Live Free Therapy, LLC policies carefully, I agree to be responsible for all charges, and I fully understand that there are no refunds. In the case of a dispute, this form, and the corresponding appointment date (s), time (s), and charges(s) will be submitted to any financial or legal institution/ person(s) associated with guaranteeing payment to Live Free Therapy. Printing my name, dating, and signing below indicate my authorization and agreement.
I, ______________________, understand that Live Free Therapy is a private psychotherapy group, and that I am responsible for the fee discussed. Fees must be paid at the time of each appointment.

Signature: ____ Date: ______________________

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Name as it appears on the card:

Card number:

Expiration date: ____/_____

Security Code: __________________

Billing address:

Billing phone number:

____________________(signature) If insurance is in network, my insurance company will be billed and I will be billed the copay, depending on if I have met my deductible or not.

Please Note:
Cancellation Policy:

Unlike professionals in other medical specialties, Live Free Therapy does not have other clients in the waiting room when a session is cancelled. As a result, it is difficult to fill a time slot when an appointment is missed, especially when it is a last minute cancellation. In order to operate in a fashion that is fair and reasonable, the following cancellation policy has been developed for those times that an unexpected event or emergency occurs.

If an appointment is cancelled with less than 24-hour notice, you will always be charged your full fee (the contract rate with insurance or your self-pay fee). This policy holds true regardless of the reason for the cancellation. However, if you need to cancel and we can reschedule your appointment sometime in the same week, you may make-up the missed appointment that you have already been charged.

If a client continues to be inconsistent with sessions and/or treatment recommendations, the therapist may refer client to another therapist in order to best serve the client's needs and best interest. If you have a planned vacation, please let us know before we schedule an appointment for that particular date.

Of course, if the therapist is not in the office for any reason, you will be notified and there will be no charge.

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Client's name: ____________________________________ D.O.B ____________________

Client's address _________________________________ Phone # __________________

City ___________________________ State _________ Zip ___________Work # ________

1. **Release of information** Ongoing communication, ☐ I authorize reciprocal information exchange as specified below. I authorize Live Free Therapy, LLC to ☐ RELEASE or ☐ OBTAIN my medical record information as specified below:

Name of individual, organization, facility or provider:

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Address ____

City _____________________________ **State**________________ **Zip**_______________

Phone___________________________ **Fax** _______________________

2. **Purpose of request:** Please specify the purpose(s) for which the information is being requested by this authorization: ☐* Personal ☐ Continuing care ☐ Transfer of care ☐ *Legal ☐ *Insurance ☐ Coordination of care ☐* Disability ☐ Workers Compensation ☐ Other

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3. **Information to be released:** Please OBTAIN, RELEASE or EXCHANGE the following health information, if such information exists:
   - ☐ All information maintained at any time by Live Free Therapy, LLC

Authorization for Release of Statutory Information PHI **cannot** be used or disclosed unless you specifically authorize such use or disclosure under 42-CFR Part 2 of the federal confidentiality regulations and Chapter 899 of the CT General Statutes**.**

I understand that signing this authorization is voluntary and that Live Free Therapy, LLC may not require me to sign this authorization before Live Free Therapy, LLC provides me with treatment. I understand that I have the right to revoke this authorization at any time by providing a signed, written notice of such revocation to Live Free Therapy, LLC. **I understand that the information released pursuant to this authorization may be re-disclosed by the recipient without our knowledge.**

4. Unless revoked sooner, this authorization expires in 1 year from the date of signature.

____ ______________

Signature of Individual Date