Community Concern of WNY, Inc. - Mental Health Clinic
HIPAA Acknowledgement and Insurance Agreement
Consent to Communicate with Primary Care Physician

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Telephone (home) _____ Cell _____ Birth date _____

Social security # _____Email _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/er

Race: ☐ Caucasian ☐ Native American ☐ African American ☐ Hispanic ☐ Asian ☐ Other

Your Rights, Confidentiality and Fee Agreement

- I have read the information regarding my rights and Community Concern's billing and business practices and that I agree to abide by its terms during our professional relationship.
- I have read received the HIPAA notice regarding my rights.
- I agree to the following conditions. Payment for services at Community Concern of WNY will be made at the time of service is rendered. If payment is not made at the time of service, there will by an additional $5.00 charge for billing you for your payment.
- I, not my insurance, will be responsible for a $25.00 charge for each missed appointment not cancelled at least 24 hours in advance.
- I understand that treatment may be stopped if I fail to make payment.

_____ _____
Client signature Date

Report To And From Primary Care Physician : (Check here if you do not give permission) ☐
I give my permission to Community Concern to release & receive information regarding my treatment to my Primary Care Physician listed below for the purpose of facilitating coordination of care. I understand that I have the right to revoke this release at any time. This release shall be valid until ninety days after my last day of treatment or until I revoke this release.

Family Physician / Practice Name _____

_____ _____
Client Signature Witness