Intake Form

COMPLETED BY (ISC REP):____________________ DATE:_____/_____/_____

CLIENT INFORMATION

CLIENT FULL NAME:____________________

DATE OF BIRTH:_____/_____/_____ AGE_____ MALE_____ FEMALE_____

SOCIAL SECURITY #:____________________ COMMUNITY:____________________

PHONE #____________________ EMAIL:____________________

CLIENT ADDRESS:____________________

CITY, STATE, ZIP:____________________

RESPONSIBLE PARTY AND/OR POA

FULL NAME:____________________

RELATIONSHIP TO CLIENT:____________________

PHONE #____________________ EMAIL:____________________

CLIENT ADDRESS:____________________

CITY, STATE, ZIP:____________________

INSURANCE INFORMATION

INSURANCE AND SUBSCRIBER INFORMATION

PRIMARY INSURANCE:____________________

POLICY ID:____________________ GROUP #:____________________

HOLDERS NAME (IF DIFFERENT FROM CLIENT):____________________

DATE OF BIRTH:_____/_____/_____ EMAIL:____________________

ADDRESS:____________________

CITY, STATE, ZIP:____________________

MEDICARE #(IF APPLICABLE):____________________

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE:______________________________

POLICY ID:______________________ GROUP #:______________________

HOLDERS NAME (IF DIFFERENT FROM CLIENT):______________________________

DATE OF BIRTH:______/______/______ EMAIL:______________________

ADDRESS:______________________________

CITY, STATE, ZIP:______________________________

*Please attach front and back copies of your insurance card(s) and face sheet to this form.

CONFIDENTIAL

Privacy Consent Form

By signing this form, you are granting consent to Inspire Senior Care and anyone acting on their behalf to use and disclose your protected health information for the purpose of treatment, payment, and health care operations. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information.

You have a legal right to review our Notice of Privacy Practices which follows before you sign this consent.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. If we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I have received a copy of the Notice of Privacy Practices.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

SECTION A: Uses and Disclosures of Protected Health Information

Under applicable law, we are required to protect the privacy of your individual health information (information we refer to in this notice as Protected Health Information). We are permitted to make certain types of uses and disclosures under applicable law for treatment, payment, and healthcare operations purposes. We are also required to provide you with this notice regarding our policies and procedures regarding your Protected Health Information (referred to as PHI) and to abide by the terms of this notice, as it may be updated from time to time.

For treatment purposes, such uses, and disclosures will take place in providing coordination, or managing healthcare and its related services by our providers, such as when someone consults with your physicians or a specialist. For payment purposes, such use and disclosure will take place to obtain or to provide reimbursement for providing medical services. For reimbursement purposes, your PHI may be disclosed to insurers, physicians, or claim administrators. For healthcare operations purposes, such use and disclosure will take place in several ways, including for quality assessment and improvement, and compliance activities; Your information could be used, for example, to assist in the evaluation of the quality of care you were provided.

We may disclose PHI about you, without your authorization, to comply with workers' compensation laws, as required by law enforcement, legal proceedings, and public health requirements, as required by law.

Other uses and disclosures will be made only with your written authorization. If there is an emergency, we may use or disclose PHI to notify, identify or locate a family member or another person responsible for your care. Such disclosure will be limited to information that is relevant to that person's involvement with your healthcare. If you object to this use or disclosure, we will do what, in our judgment, is in your best interest regarding such disclosure.

If you believe that your privacy rights have been violated, you may file a complaint with us at the location described in Section B, or with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

SECTION B: CONTACT INFO

You may contact us for further information at:
(P): (888)-367-8209
(E): ClientService@InspireSeniorCare.com

CLIENT AUTHORIZATION
☐ I, the undersigned am the client, or the clients duly authorized representative, and do hereby voluntarily consent to and authorize the evaluation and treatment by Inspire Senior Care and their Clinicians, and/or agents. Furthermore, I understand Inspire Senior Care and its Clinicians and/or agents may speak with a family member and/or Power of Attorney regarding care for the client receiving treatment and may communicate and share information with resident staff and other health care providers as necessary. ☐ I, the undersigned am the client, or the clients duly authorized representative, and do hereby authorize Inspire Senior Care and their Clinicians, and/or agents to bill the clients Insurance and release all medical information necessary to process claims, including by electronic means if available and request benefits to be paid to the rendering provider. ☐ I acknowledge that a copy of Inspire Senior Cares "Notice of Privacy Practices" has been received and reviewed by the client or the clients authorized representative/Power of Attorney.
PATIENT NAME:______________________________ SIGNATURE:____________________ DATE:____________________ IF NOT SIGNED BY CLIENT, I hereby attest that I have the legal authority to and do authorize mental health counseling and brain health services for my ______________ as their power of attorney. ________ (Initial)