

WISDOM TRADITIONS

Counseling Services, LLC

Client Name	Chart Number	Marital Status	Referral Source
SSN#			
Mailing Address	Date of Birth	Gender	Ethnicity
	Home Phone	Work Phone	Cell Phone
Person Financially Responsible for Account	Home Phone	Work Phone	Cell Phone
Mailing Address			

Primary Insurance Company	Phone	Group Number	Subscriber Number
Billing Address			
Subscriber Name	Phone	Date of Birth	Relationship to Client
Address			
Secondary Insurance Company	Phone	Group Number	Subscriber Number
Billing Address			
Subscriber Name	Phone	Date of Birth	Relationship to Client
Address			

Emergency Contact	Day Phone	Evening Phone	Relationship to Client
Form Completed by (Print/Sign):			Date

401 West International Airport Rd. #17 * Anchorage, Alaska 99518
 Phone: 907-770-3656 Fax: 907-562-4503

WISDOM TRADITIONS
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I, _____, authorize reciprocal release of information
(*client or guardian signing on behalf of the client*) between Wisdom Traditions and

_____.

Regarding: _____ DOB: _____ SSN: _____
(*Name of client or "Self" if client is own guardian*)

I authorize the administrative, program and clinical staff of Wisdom Traditions to use this information, and/or disclose this protected health information. If the records pertain to alcohol and/or drug treatment, I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2. I understand that records pertaining to medical information and/or Mental Health services records are covered by the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my consent unless otherwise provided for in the regulations. I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken in reliance on it, and that by any event this consent expires automatically as follows:

(Specification of the date, even, or condition of expiration.)

I understand that Wisdom Traditions may not condition my treatment on whether I sign a consent form, but that in certain limited conditions I may be denied treatment if I do not sign a consent form.

Client Signature

Date

Parent/Guardian/Authorized representative

Date

Witness

Date

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- I have received and reviewed a copy of: FAQs & a Waiver of Liability
- I have received and reviewed a copy of Standards of Confidentiality of Patient Records under the Health Insurance Portability and Accountability Act (HIPPA, 45 CFR).
- I have received and reviewed a copy of the Licensed Professional Counselor Disclosure Statement.
- I consent to the treatment which may be initiated during this visit and for ongoing treatment as a patient of Wisdom Traditions Counseling Services, LLC.
- If patient is a minor, I hereby authorize treatment.

Client/Guardian Signature

Date