CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by RGM Psychotherapy Resources, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of RGM Psychotherapy Resources, Inc. I understand that diagnosis or treatment of me by Raymond Messer, MSW, LISW may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. RGM Psychotherapy Resources, Inc. is not required to agree to the restrictions that I have requested. However, if RGM Psychotherapy Resources, Inc. agrees to a restriction that I request, the restrictions is binding on RGM Psychotherapy and Mr. Messer.

I have the right to revoke this consent, in writing, at any time, except to the extent that RGM Psychotherapy Resources, Inc. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have the right to review RGM Psychotherapy Resources' Notice of Privacy Practices prior to signing this document. A copy of RGM Psychotherapy Resources' Notice of Privacy Practices bas been provided to me.

Initial here verifying your receipt of the Notice ________

The Notice of Privacy Practices (final page of this series) identifies the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of RGM Psychotherapy Resources, Inc. The Notice or Privacy Practices for RGM Psychotherapy Resources is also posted in the waiting area. This Notice of Privacy Practices also describes my rights and RGM Psychotherapy Resources' duties with respect to my protected health information.

RGM Psychotherapy Resources reserves the right to change the privacy practices that are described. I may obtain a revised notice of the privacy practices by calling the office and requesting that a revised copy be sent in the mail or by asking for one at the time of my next appointment.

____
Name of Patient

____
Signature Patient/Personal Representative

____
Personal Representative's Authority (e.g., self, parent, etc.)

CONSENT TO SPECIFIC DISCLOSURES OR RESTRICTIONS

Please answer the following questions by placing your initials in the column of your chosen response. Please put any specific instructions in the space provided.

	Yes	No	Specific Instruction
Can we contact you at home by phone or mail?			
Can we contact you at work, including leaving messages?			
Can we leave messages on voice mail, answering machines, or with a family member?			
Can we email messages containing your information to parties included in this consent? If YES also read & sign the email policy statement			
Do you have an additional/alternative phone number or address you wish to be used to contact you? Please specify information to the right.			

I hereby give consent to RGM Psychotherapy Resources, Inc. to contact me as indicated above. I understand that I may revoke this consent in writing to the extent it has not already been relied upon.

____
Signature

____
Date