Fairbanks Therapy Associates Inc.

helping navigate life's journey

Client Information **Date:** _____

Last name		**First name**		**MI**	
DOB			**SS#**		
Address			**City**		
State			**Zip**		
Home phone			**Cell phone**		
Email			**Employer**		
Insurance Co			**Primary insured**		
Insured DOB			**Insured SS#**		
Subscriber ID			**Group #**		
Plan name			**Ins phone**		
Ins address			**Deductible**		
Copay					

Fairbanks Therapy Associates Inc.
PO Box 82842, Fairbanks, AK 99708
907-452-2473 f: 452-6903
www.FairbanksTherapyAssociates.com
FTA@FairbanksTherapyAssociates.com

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home of the LEAP program

Consent Release & Exchange of Confidential Information

I, _____ DOB: _____, give authorize Fairbanks Therapy Associates (FTA) to release and receive confidential information to/from the following agency(ies):

(please initial)

- ☐ Adult Probation (DOC)
- ☐ Alaska Court System
- ☐ Alaska State Troopers (AST)
- ☐ Child Custody Investigators (CCI)
- ☐ Child Support Enforcement (CSED)
- ☐ District Attorney (DA)
- ☐ Fairbanks Police Department (FPD)
- ☐ Guardian Ad Litem (GAL)
- ☐ Interior Alaska Center for Non-Violent Living (IAC)
- ☐ Office of Children's Services (OCS)
- ☐ Office of Public Advocacy (OPA)
- ☐ Public Defender (PD)
- ☐ Resource Center for Parents & Children (RCPC)
- ☐ CDVSA
- ☐ Other: _____

I authorize confidential information to be released from:

_____

to Fairbanks Therapy Associates Inc. (FTA) home of the LEAP program at PO Box 82842 Fairbanks, AK 99708 907-452-2473 fax: 452-6903. Encrypted email: secure@LEAPFbks.hushmail.com

The *PURPOSE* of this consent is to improve assessment and treatment planning, share information, share information relevant to treatment and, when appropriate, coordinate treatment services. I understand that the Provider cannot guarantee that the Recipient will not re-disclose my confidential information to a third party. I understand that I have a right to revoke this consent, in writing, at any time by sending written notification to the receptionist at FTA. I further understand that a revocation of the consent is not effective to the extent that action bas been taken in reliance on the consent. I further understand that FTA will not condition my treatment on whether I give consent for the requested disclosure. Unless you have specifically requested in writing that this disclosure be made in a certain format, we reserve the right to disclose information as permitted by this consent in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to verbally, in paper format or electronically. I will be provided a copy of this consent at my request. This consent for the release of information shall begin on the date of my signature and shall remain in effect for the next twelve months or until I have notified FTA Inc., in writing, of otherwise.

_____ _____

Client Signature Date

_____ _____

Witness Date

RECIPIENT INFORMATION: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

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CREDIT CARD ON FILE POLICY

At FTA/LEAP Inc. we require keeping your credit or debit card in file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable and/or for any balance that is over sixty (60) days aged. Without this authorization, all initial services must be paid at the time of service. Your credit card information will be kept confidential and secure in a locked filing cabinet within your personal file. We will make you aware of charges before running your card at any time.

I authorize FTA/LEAP, Inc. to charge the portion of my bill that is my financial responsibility over sixty (60) days aged to the following credit or debit card:

☐ **Amex** ☐ **Visa** ☐ **MasterCard** ☐ **Discover**

Credit Card Number_____

Expiration Date: _____/_____ **Security Code:** _____

Cardholder Name: _____

Billing Zip Code: _____

Client allowed Credit Card on file: _____ **Date:** _____

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