Forensic Consultation & Counseling Service, LLC
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CONSENT AND AGREEMENT TO USE AND DISCLOSE HEALTH INFORMATION FOR PAYMENT AND HEALTH CARE OPERATIONS

Name: ______________________________________ Case #: _________________

DOB: _____/_____/_____ SSN: ______ _______ _____

Payment or subsidy for behavioral health (mental health / substance abuse) treatment by a third party is contingent upon supplying information regarding your mental health / substance abuse condition and treatment to those parties. I understand that if I refuse the release of this information that I may be held responsible for full payment for services received. I agree to pay all fees and understand a late fee of 10% of total amount due will be applied to payments more than 30 days late from the current billing statement.

All accounts more than 60 days past due may be referred to a collection agency for collection purposes.
FCCS, LLC uses- **FEDChex** 2 Venture Plaza, Suite 300, Irvine, CA 92618
1-800-992-6713
All accounts referred to a collection agency will result in additional fees to cover the expense associated with collection efforts. This fee will be a 30% charge on the total amount outstanding and will be added to the total amount due. I hereby authorize Forensic Consultation & Counseling Service, LLC to exchange verbal or written information relevant to my mental health / substance abuse condition and treatment with:

_______Department of Vermont Health Access & it's managing partners (Medicaid / Gr. Mtn Care, etc.)
______ MVP Healthcare ______ Magellan Network Providers ______Cigna________Self-pay
______ BC/BS _________Other Insurance or Managed Care Company: ___________________
_√___ FEDChex _√____ Dominion Labs

Periodic professional review of case records by Forensic Consultation & Counseling Service, LLC. State and National certifying, accredited, or licensing bodies may be necessary to ensure high quality standards of service. All such reviews are handled under our policy of strict confidentiality. I hereby authorize the review of my case records for such purposes. This information will be provided for the purpose of determining the appropriateness of my treatment, for claims administration, for continuity of care and for quality assurance. I understand that this information will be maintained in a confidential manner and will be used only for the reasons stated herein. I understand that I have the right to withdraw this authorization at any time unless action based upon it has already been taken. If I do not revoke it, this permission will expire automatically two years after all claims for behavioral health services have been paid. I also understand that further disclosure of the information may not be made without my written consent or as otherwise permitted by Federal &/or State law.

I also understand that alcohol and drug abuse client records are protected by 42CFR part 2, and that records may not be released or disclosed without my written consent unless otherwise provided for in the regulation.
I have been provided with a full Notice of Privacy Practice that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I also understand that I have the right to request restrictions of the use and disclosure of my health information.

Signed _______________________________________ Date: ___________________
(Client) (parent/guardian if needed)

Signed _______________________________________ Date: ____________________

Revised 08/01/2019