Edgewood

Annual Information Update 2019

Please return to ECS Staff at your first appointment of 2019

Client Full Name: _____ Date of Birth: _____

CONSENT FOR TREATMENT

I consent to the evaluation and treatment process with Edgewood Clinical Services, and I understand that this process may include myself, my spouse, my children, and/or other family members. I understand that I have the right to withdraw from treatment at any time. I understand that if I am a divorced parent of a child, my ex-spouse may be informed of our child's treatment at Edgewood. I understand that the number of visits I receive will depend on the type(s) of issues that exist, the recommendations made, and the effort that I (client) put forth by following suggested recommendations.

I have had the opportunity to review all 2019 changes and fee updates as listed in their entirety online at EdgewoodClinicalServices.com and at the front desk at each location. By signing below, I reaffirm my consent to all 2019 updates, and the evaluation and treatment process with Edgewood Clinical Services. I further understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. Copies of any consents previously signed may be requested at any time. Updated consents for release of information to other providers or individuals involved in my treatment are required every 12 months and should be re-filled out with your clinician.

Client Signature *(Client 12 & over)*: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

OPTIONAL Co-Custodial Guardian Signature: _____ Date: _____

Are you covered under Medicaid or Medicare as primary or secondary insurance? Yes ☐ No ☐

If yes, please fill out Medicaid/Medicare Opt-Out Agreement Form

INSURANCE INFORMATION (*Disclaimer: Edgewood Clinical Services is not a participating provider with Medicaid or Medicare.)*

Name of Primary Insurance: _____ Member ID: _____

Group Number: _____ Policy Holder Name: _____ Policy Holder DOB: _____

SECONDARY INSURANCE

Are you covered under any other insurance plans: Yes ☐ No ☐

If yes, please fill out the below secondary insurance information

Name of Secondary Insurance: _____ Member ID: _____

Group Number: _____ Policy Holder Name: _____ Policy Holder DOB: _____

**** Please provide insurance card to be copied at the office as soon as it become available.

IF ANY DEMOGRAPHIC INFORMATION HAS CHANGED IN THE LAST 12 MONTHS, PLEASE COMPLETE BELOW:

Primary Street Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____

********READ AND COMPLETE ENTIRE FORM ********

Staff Initials/Date: _____