



Client Information

Date: _____ Age / DoB: _____

Client's full legal name: _____

Preferred name: _____

Biological Sex: Male / Female Gender identity: _____

Marital Status: _____ Race: _____ Education: _____

Phone numbers: _____

Permission to send Texts / Voicemails: (circle) **Yes / No** (If no, please speak to receptionist)

Emails: _____

Permission to send Emails: (circle) **Yes / No**

Primary Address: _____

City: _____ State: _____ Zip: _____

Occupation/Employer/School: _____

Referral source: _____

Doctors / Agency: _____

Emergency contact: _____ Phone: _____

By signing below, I hereby attest that the information above is accurate to the best of my knowledge, and I agree it is my responsibility to update CCCS when any of the above information changes. I agree to receiving emails, phone calls or text messages from CCCS related to my treatment; including optional automated text appointment reminders.

Client Signature

Date

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Introduction to Services

Welcome, we are glad you are here! Please understand the following information on our services

1. CCCS is an Iowa Chapter 24 accredited mental health agency, held to the state's highest standards in mental health services. Our staff are dedicated to treating all clients with dignity and respect, and to operate in accordance with client-centered, and trauma-informed practices.
2. Our goal is to help you meet your goals. Without your consistent and active participation in sessions, and collaboratively steering treatment goals and decisions, your goals and growth are unlikely to change through these services. We believe you should understand the purpose and rationale of the services you are engaging in each step of the way. You are encouraged to ask questions and give feedback to providers and staff to ensure your needs are understood and met.
3. Using a combination of psychoanalytic and behavioral approaches to help you find, and live, your best life, treatment generally focuses on the following processes:
 - a. Increasing self-awareness and understanding relational dynamics
 - b. Internalizing personal responsibility toward making change
 - c. Exploring barriers to change and incongruence in thoughts, emotions, and behaviors
 - d. Enacting and maintaining new efforts to improve circumstances and personal growth
4. In accordance with state, licensing, and payor requirements, and ethical best practice, your provider participates in peer and group supervision with other agency providers, and in individual supervision with the agency director who oversees treatment and documentation related to all agency operations.
5. CCCS provides services in good faith toward legitimate personal desire for change and growth. Participation in CCCS services is voluntary for all parties involved (regardless of legal or other obligation). Either party is free to end treatment or change providers to ensure the ethical provision of services in a safe, therapeutic environment for you, other clients and families, and our staff - whether in our offices or in our communities. If CCCS finds a need to make a change that affects you, you will be informed, and your perspective considered in making treatment decisions. You may discontinue services at any time, however, it is best to discuss this decision with your provider first.
6. Our services are not intended to achieve any aim related to meeting external goals, including extraction or validation of information for custody or other legal issues; nor to the purposes of other entities like DHS, the court, or an employer - unless those needs align with the Client's self-determined goals.
7. Agency personnel must be legally served a subpoena in order to testify in court. Agency personnel will charge a court appearance fee for testimony as this service requires a significant amount of preparation and expense related to canceling and rescheduling other client's appointments, extra travel, seeking supervision, and reviewing documentation to prepare testimony.

The signature below indicates understanding and acceptance of these service policies.

I will only sign after I understand and agree to the above policies.

Client Signature

Date

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Appointments and Financial Responsibility

1. Services work best with intention and consistency. It is the Client's responsibility to attend and participate in scheduled appointments. Sessions are generally scheduled on a weekly, or bi-weekly basis; unless otherwise requested and collaboratively agreed between you and your provider.
2. Cancellation of appointments is expected with 24 hours prior notice whenever possible. Cancellation allows us planful use of that time for various other needs, and to reschedule other clients who may be waiting for an opening. This only takes a quick call, text, or email to the office, or to your provider if they choose to allow direct communication with clients.
3. Failure to attend scheduled appointments -without cancellation- is considered a no-show resulting in a \$30 no-show fee added to your account depending on our contractual conditions with your insurance.
4. After three consecutive no-shows, all future scheduled appointments will be canceled. You are welcome to request to resume services – which you will then have to initiate. Resuming services will depend on the provider's agreement and availability, and your account being brought up to date. You will not be guaranteed your previous schedule, and may be put on a cancellation waitlist.
5. Appointment charges, deductible, co-payment, existing balance, or other Client financial responsibility is due at the time of service or by the terms of a payment plan agreement with the Agency. In case of financial limitations, please speak with our office staff. We frequently work with clients to facilitate services when financial difficulties are present.
6. The Client, regardless of insurance coverage, is ultimately responsible for payment of provided services and no-show fees - unless under specific contractual circumstances with your insurance. We will help you understand how your insurance policy contributes to payment of services as best we can, however, it is in your best interest to understand the basic terms of your policy related to co-payment and coverage periods. It is your responsibility to keep the agency up to date with any and all applicable changes to your health insurance coverage to avoid increased financial responsibility.
7. Ongoing complications with meeting financial responsibilities may result in a pause in services until a payment agreement can be reached. In the event that a payment agreement is not reached, or if the client does not participate in efforts to address the balance owed, termination of services may occur, and the past due account may ultimately need to be pursued by a collection agency.

Signature below indicates the Client's understanding and agreement of their responsibility to attend or cancel all scheduled sessions, and to fulfill their financial responsibility as outlined in this document. I will only sign when I understand and agree to the above information.

Client Signature

Date

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Confidentiality

CCCS utilizes an online HIPAA-compliant electronic health record platform. Each client's digital clinical chart contains all information related to treatment, including: demographics, appointments, intake information, treatment planning, and progress notes. Your records will not be released to any entity without your prior written consent, unless in these situations as outlined below:

Issues discussed in therapy are private, personal, and are generally legally protected as confidential and "privileged" under HIPAA. There are limits to the privilege of confidentiality. All CCCS providers are legal Mandatory Reporters under the criteria set forth by the State of Iowa. Limits of confidentiality include:

1. Suspected physical, emotional or sexual abuse, or neglect, of a dependent child, or a dependent elderly or disabled individual as outlined in Iowa Mandatory Reporter criteria.
2. If your provider believes that you have serious intent of significantly harming or injuring yourself or another; that self or other are in danger of intentional loss of life, or you are unable to protect yourself.
3. When an insurance entity is paying toward services, we are contractually required to share client information related to filing a claim, documentation audits, case review, appeals, and other processes.
4. CCCS providers participate in peer, group, and individual case supervision in accordance with state, professional, and insurance standards and best practices. All CCCS staff are bound to confidentiality.
5. If your provider is subpoenaed to release sensitive client information for legal purposes, our policy is to resist that request until unavoidable - and then request release only under limited access. This is not a guaranteed request, and at times we are legally compelled to comply. CCCS is not responsible for being legally compelled to release records, is not responsible for records after their release, and is not responsible for the consequences of release.
6. In the event of natural disasters, or vandalism, protected records may become unavoidably exposed.
7. Iowa Chapter 24 accreditation requires occasional Agency documentation audits.

You may request, or may be requested to sign a limited release of information form to enable Agency staff to share information about your case, verbally or in writing, with anyone you identify. This includes family members, professionals, or other service providers (teachers, lawyers, doctors). Without documented release of information authorization, or legal compulsion, providers cannot and will not engage in discussions, write letters, or share or report information to any outside entity pertaining to your case.

CCCS will not be held liable to any damages or breach of confidentiality under the terms in this document.

The signature below indicates understanding and acceptance of this service policy.

I will only sign when I understand and agree to the above information.

Client Signature

Date

The confidentiality of this information is protected by federal laws including the Health Insurance Portability and Accountability Act of 1996 and the Code of Federal Regulations (42CFR Part2 Public Law 93-282, Section 2:31(a) and 2:33) as well as the Iowa law (Iowa code Chapter 28). Iowa law requires that disclosures can only be made pursuant to the written authorization of the patient or the patient's legal representative. Civil and or criminal penalties may apply to the unauthorized disclosures of mental health information.

Client Rights and Responsibilities

Much of the therapeutic process takes place between sessions. Your progress may be based on your use of therapeutic feedback and direction outside of sessions. You may be asked to complete questionnaires or assignments. The client understands that it is their responsibility to put forth adequate effort in their treatment to produce results - not that of the therapist. All clients share in the following rights and responsibilities while engaged in services with CCCS:

1. To be treated with dignity and respect for your personal values and beliefs.
2. Your privacy and confidentiality will be protected in accordance with our confidentiality policy.
3. To receive reasonable access to services regardless of race, religion, gender, sexual orientation, ethnicity, age, or physical ability.
4. Will be informed, and included in processes and decisions related to your treatment.
5. Can discuss with Providers, medically necessary treatment options regardless of cost or coverage.
6. Have the right to include or exclude family participation in treatment planning if you so choose.
7. Clients over 12 years of age may participate in treatment planning when developmentally appropriate.
8. Clients have the right to individualized treatment, including:
 - a. Adequate and humane services regardless of source(s) of financial support.
 - b. Provision of services within the least restrictive environment available.
 - c. An Individualized, and periodically reviewed treatment plan.
 - d. Competent, qualified clinical staff to provide treatment.
9. Designate a surrogate decision-maker if the client requires, or so chooses.
10. To subpoena their therapist and request documentation or letters for court as outlined above.
11. Participate in the consideration of ethical issues that may arise in the provision of services.

Access to services is dependent on our ability to maintain a safe, respectful, and healthy therapeutic environment for all clients and families. Clients acknowledge that they may be asked to leave if Agency personnel find the environment to be jeopardized in any way. If a client refuses to comply with such a request, police will be called to intervene to maintain the safety of all clients and Agency staff.

1. Violence will not be tolerated: physical, verbal, or non-verbal (simulated or gestured).
2. Clients are responsible for any children they bring to the premises and are not to leave children unaccompanied or unattended on Agency grounds.
3. Clients will not be on Agency grounds under influence of intoxicants, nor with any substances.

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Client Signature

Date

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Client Grievance and Appeals Policy

We make our best effort to satisfy all client questions or concerns, however, situations may arise in which a client has an unresolved grievance. We believe a well-handled grievance can facilitate communication and understanding in order to be resolved in a healthy manner. Each client grievance will be documented when officially brought to our attention in writing. Clients may request a grievance form from office staff in order to file an official grievance. Detailed notes will be taken at any and all meetings related to an officially filed grievance.

The following steps will be followed when a client files an official grievance:

1. Since most concerns are minor, or the result of a misunderstanding, the first recourse is for the affected parties to discuss and attempt to resolve the matter between them. This will typically happen as a grievance is shared, or within a week of a raised issue, or at the Client's next appointment.
2. If the first effort fails to resolve the Client's concern, a meeting with the Client, Provider, and Agency Director can be requested. The Client is welcome to bring a third party to participate in this resolution. This meeting will attempt to be scheduled within a week of the first attempt at resolution, in place of Client's next appointment, or as parties are reasonably available.
3. If the Client's concern is not resolved by the second effort the client may request to meet with the Director alone. The Director will assess the likelihood of a resolution. If, after consultation, a third meeting seems helpful, one will be scheduled with the client within one week, or in place of the next appointment.
4. If this third step fails to resolve the issue, the Client will be provided with a referral to another Provider or to a different Agency. The treating Provider will make reasonable efforts to assist the client in this process as available and as appropriate.

The signature below indicates understanding and acceptance of this service policy.
I will only sign when I understand and agree to the above information.

Client Signature

Date

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Telehealth Consent Form

Telehealth is healthcare provided by any means other than a face-to-face visit. This opens up more options for scheduling or rescheduling appointments. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

By signing at the bottom of this page you consent to the following conditions:

1. I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.
2. I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.
3. I understand that telehealth services can only be provided to patients, including myself, who are residing in a state where my provider is licensed at the time of this service.
4. I understand that telehealth billing information is collected in the same manner as a regular office visit.
5. My financial responsibility will be determined by my insurance carrier, and it is my responsibility to check with my insurance plan to determine coverage. Lack of coverage will result in a bill.
6. I understand that information exchanged during my telehealth visit will be maintained by providers, and facilities involved in my care.
7. I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records.
8. I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.
9. I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
 - It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
 - Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
 - Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

The signature below indicates understanding and acceptance of this service policy.
I will only sign when I understand and agree to the above information.

Client Signature

Date

The confidentiality of this information is protected by federal laws including the Health Insurance Portability and Accountability Act of 1996 and the Code of Federal Regulations (42CFR Part 2 Public Law 93-282, Section 2:31(a) and 2:33) as well as the Iowa law (Iowa code Chapter 28). Iowa law requires that disclosures can only be made pursuant to the written authorization of the patient or the patient's legal representative. Civil and or criminal penalties may apply to the unauthorized disclosures of mental health information.

Client Consent to use of Automated Note Writing Software

With current advances in time-saving technologies, many clinicians have begun utilizing AI driven transcription software during sessions to generate session documentation. This saves your clinician hours of documentation time each week to free up time for case review, conceptualization and preparation between sessions, as well as ensuring accuracy of session content. Clinicians are required to edit AI generated notes for accuracy before adding documentation to your clinical file.

Tool Functionality:

- The tool converts our conversations into notes and clinical documentation.
- It uses speech to text technology to create a transcript of our interaction and deletes the transcript once the note or document has been created.

Data Retention Policy:

- Session audio is not stored in any system
- Transcripts are de-identified with any personal information and disassociated with the record after 14 days.
- Clinicians may save notes for longer as part of your medical record.

HIPAA Compliance and Patient Data Rights:

- We adhere to HIPAA standards, ensuring the security and confidentiality of your health information.
- You have rights under HIPAA, including accessing your records and requesting amendments.

The signature below indicates understanding and consent to the use of this documentation tool in your sessions with CCCS clinicians. You acknowledge the data retention policy and understand your rights under HIPAA regarding your health information. I will only sign when I understand and agree to the above information.

Client Signature

Date

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Date:

Dear Dr.

I would like to take this opportunity to inform you that _____,
(DoB) _____, has recently become a client at our agency, and has
identified you as their medical doctor. I am informing you of this information for professional
courtesy and to ensure continuity of care. My current diagnosis for this client is:

_____.

The mission of Community Centered Counseling Services is to provide superior client-centered
professional counseling, therapy and behavioral health services to empower children, adults,
couples and families toward achieving healthy and long-lasting life changes.

When necessary and to provide the highest quality of service, I will inform you of any ongoing
issues in treatment and we hope you will reciprocate in kind. Should you have any questions or
concerns, please do not hesitate to contact me. The patient and/or patient's parent/legal
guardian has signed a current release of information which can be faxed to you as needed.

Sincerely,

Client may Opt out of sending this letter for confidentiality ☐

Client Signature

Date

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

☐ ☐ PICA		☐ ☐ PICA	
1. MEDICARE ☐ (Medicare #) ☐ MEDICAID ☐ (Medicaid #) ☐ TRICARE CHAMPUS ☐ (Sponsor's SSN) ☐ CHAMPVA ☐ (Member ID#) ☐ GROUP HEALTH PLAN ☐ (SSN or ID) ☐ FECA BLK LUNG ☐ (SSN) ☐ OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
TELEPHONE (Include Area Code) ()		TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☐ NO c. OTHER ACCIDENT? ☐ YES ☐ NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐		a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED _____ DATE _____		SIGNED _____	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER	
25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐		26. PATIENT'S ACCOUNT NO.	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____	
SIGNED _____ DATE _____		33. BILLING PROVIDER INFO & PH. # () a. _____ b. _____	

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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