RENEWED JOURNEY COUNSELING SERVICES, LLC
1479 BROCKETT ROAD SUITE 101 TUCKER, GA 30084
O: (404) 625-5427 F: (404) 508-8944
WWW.RENEWEDJOURNEY.ORG

Client's Name: _____ Date of Birth: _____

Parent's Name (if applicable): _____

Health Insurance Portability and Accountability Act (HIPAA) Rights:

I acknowledge Renewed Journey Counseling Services, LLC adheres to the federal mandates of the HIPAA laws. My signature below acknowledges receipt of this notice. I am able to receive the full disclose in print, email, or by fax, upon request.

_____ _____
Patient or Authorized Person's Signature Date

AUTHORIZING BILLING

I authorize the Release of any medical or other information necessary to process my health care claims understanding that all information shared is protected health information and will fall in compliance to HIPAA laws. I also request payment of government benefits either to myself or to RJCS.

_____ _____
Patient or Authorized Person's Signature Date

I authorize payment of medical benefits to the assigned clinician or contracted billing agent for healthcare services rendered.

_____ _____
Patient or Authorized Person's Signature Date

_____ I decline courtesy billing from Renewed Journey Counseling, LLC on my behalf. I am responsible for payment at time of service, but will submit insurance claims on my own with the receipt supplied.

Policy Holder's Name:
Address:
Date of Birth:

- *These statements summarize the HIPAA form and Health Insurance Claim Form-1500*