

**PSYCHOLOGICAL AND SCHOOL SERVICES OF EASTERN CAROLINA, PLLC**

**KELLY C. MOYNAHAN, PhD, LPA, HSP-LPA**

1025 Director Court, Suite A/1, Greenville, NC 27858

**New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Options**

I understand that as part of my healthcare, Kelly Moynahan, PhD, LPA, HSP-LPA, dba Psychological and School Services of Eastern Carolina, PLLC, originates and maintains paper and/or electronic records describing my health history, symptoms, diagnosis, treatment and plans, for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means to communicate among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and

I understand and been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. In understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent,
- The right to object the use of my health information for directory purposes, and
- The right to request restrictions as to how health information may be used or disclosed to carry out treatment, payment or health care operations (for example, you can request to self-pay and restrict any information being released to your insurance company).

I understand that Kelly Moynahan, PhD, LPA, HSP-LPA, dba Psychological and School Services of Eastern Carolina, PLLC, is not required to agree to the restrictions requested (for example, a court order may require limited or full access to your record). I understand that I may revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Kelly Moynahan, PhD, LPA, HSP-LPA, dba Psychological and School Services of Eastern Carolina, PLLC, reserves the right to change he notice and practices prior to implementation, in accordance with by Section 164.506 of the Code of Federal Regulations. Should Kelly Moynahan, PhD, LPA, HSP-LPA, dba Psychological and School Services of Eastern Carolina, PLLC, change her notice, she will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that, as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose protected information to another entity, and I consent to such disclosure for these permitted uses, including disclosures, via fax or electronic mail or electronic billing.

I fully understand and accept/decline the terms of this consent.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN OF PATIENT \_\_\_\_\_ - - - - - DATE \_\_\_\_\_

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**FOR OFFICE USE ONLY**

- ( ) Consent received
- ( ) Consent refused by patient and treatment refused as permitted
- ( ) Consent refused by patient and treatment allowed

