HINKLE & ASSOCIATES LLC
Insurance Information

Primary Insurance Name:_____ Address:_____
City and State:_____ Phone Number:_____
Policy Holder Name:_____ DOB:_____ Relationship_____
ID Number:_____ Group Number:_____

Consent to use and disclose your Protected Health Information

This form is an agreement between you, _____, and the provider, Patrick J. Hinkle, MA, LPC, LCMFT. When we use the word "you" below, it can mean you, your, child, a relative or other person, if you have written his or her name here: _____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign the Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at 913-438-2100 or from your provider.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may have used or shared some of your information and cannot change that.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____
Description of personal representative's authority

_____
Signature of authorized representative of this office or practice
Date of NPP _____ ☐ Copy given to the client/parent/personal representative.