LIFESOURCE

Healthcare Management Services

Patient Demographics

Patient Full Name: _____ **DOB:** _____/_____/_____

Gender: M F **Marital Status:** M W D S **SSN:** _____/_____/_____

Address: _____

_____

Insurance Information: please have card(s) available for photocopy

Primary Insurance: _____ **Subscriber #:** _____

Policy Holder (if not patient):_____ DOB: _____

Secondary Insurance: _____ **Subscriber #:** _____

Policy Holder (if not patient):_____ DOB: _____

Financially Responsible Party:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Referred by: _____

Reason for Referral: _____

_____

Service(s) requested: Psychiatry Y N Psychotherapy Y N Primary Care Y N
South Carolina Only

FAX: NC/SC East: 888-746-1787 NC/SC Central: 866-308-6752 NC/SC West: 877-510-4832

LifeSource, Inc. P.O. Box 15390, Wilmington, NC 28408 – Phone: 910.742.9243

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Healthcare Management Services

Request for Healthcare Services: Patient Authorization

Patient Name: _____ **Patient DOB:** _____

Patient Location: _____

Service(s) Requested: ☐ **Psychiatry** ☐ **Psychotherapy** ☐ **Primary Care**
South Carolina only

I request the above services from the LifeSource of NC, Inc. clinician designee(s).

I have been informed of my rights, including the right to consent to or refuse treatment; I have received or been offered a copy of LifeSource's Notice of Privacy Practices, Client Rights' and Grievance policies, which provide information about how LifeSource uses and discloses Protected Health Information.

I authorize any entity with medical information about me to release said information to my insurance company or to the Centers for Medicare and Medicaid Services and its agents, if needed, to determine the benefits payable for requested services.

I request that payment of authorized insurance benefits be made on my behalf to the LifeSource clinician designee for requested services. I understand that my insurance company may assign a portion of the bill as patient liability. I understand that my financially responsible party may be informed that I am receiving services for billing purposes unless I request otherwise.

I authorize the release of information to my Attending Physician and/or facility for the purpose of coordination of care. I understand that my medical records will be kept on file at the site where requested services are provided, and that the release/ disclosure of my protected health information is subject to all HIPAA guidelines. The duration of this consent is until the discontinuation of service by the provider or patient.

REQUIRED SIGNATURES: ***(If POA signs on patient behalf, proof of invoked POA status is required)***

_____	_____	_____
Patient or Legal Guardian Signature	Patient or Legal Guardian Printed Name	Date
_____	_____	_____
Witness Signature *(If signature illegible)*	Witness Printed Name	Date

Or, in accordance with Medical Statutes:

_____	_____	_____
Responsible Party Signature	Responsible Party Printed Name	Date

Relationship to Patient (required): _____

Healthcare Management Services

Consent to Disclosure of PHI to Family Members, Relatives, Friends or Others

Patient Name: _____ DOB: _____/_____/_____

I understand that, if I am present, LifeSource may disclose my PHI to other family members, relatives or friends if I orally agree or do not object.

I also understand that, if I am not present or am incapacitated, LifeSource may make limited disclosure of my PHI to other family members, relatives or friends if LifeSource determines in its professional judgment that such disclosure is in my best interest.

I agree that LifeSource may disclose my PHI to the following family members, relatives, friends or others

NAME	RELATIONSHIP	PHONE NUMBER

REQUIRED SIGNATURES: ***(If POA signs on patient behalf, proof of invoked POA status is required)***

_____ _____ _____

Patient or Legal Guardian Signature | Patient or Legal Guardian Printed Name | Date

_____ _____ _____

POA Signature (if applicable) | POA Printed Name (if applicable) | Date