Peter J. Paterno, MSW, LCSW

Practice in Psychotherapy and Professional Coaching

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Confidentiality Statement and Authorization to Bill Insurance

I understand that my records are protected under the applicable law governing healthcare information that relates to mental health services and under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 cfr part 2, cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations or in situations where my safety or the safety of others is at risk. I also understand that I may revoke this consent at any time except that action has been taken in reliance thereon and that in any event this consent will terminate 180 days from the date of the authorizing signature or six months after treatment is terminated whichever is greater.

I, _____, authorize Peter J. Paterno, LCSW to release any and all information which may include addiction information requested by my insurance for the purpose of paying claims, outcome studies or authorizing further care.

SIGNATURE:_____ Date:_____ Witness:_____

I authorize my insurance company to pay directly for services billed. I however, acknowledge that both I and or the person signing below, are ultimately responsible for all fees including co-payments and fees not paid by our insurance (BECAUSE YOU WERE EITHER NOT COVERED OR YOUR INSURANCE DISAGREED WITH THE TREAMENT TO WHICH YOU AGREED AND WILL NOT PAY). This is in effect unless prohibited by hold harmless clause in the contract between Peter J. Paterno, LCSW and your insurance company. **I also agree to pay additional fees for medical record copies and ANY kind of report (Court, disability, etc.).**

SIGNATURE:_____ Date:_____ Witness:_____