Providing Spirit-empowered Service to Individuals at their Point of Need

RNLF Counseling Services

When you are in treatment, what your doctors need to know……

When you, or your family member, need to see more than one type of healthcare professional, your care can become more complex. This is true whether you see more than one doctor or a therapist.

You may ask:

- Why is it anybody's business when I go to therapy or see a psychiatrist?
- Why do my doctors need to know about my personal problems?

The answer to these questions should be discussed with your doctor or therapist. However, it is very important for doctors and therapists to communicate at these times.

- **When you start therapy:** Sometimes problems can be caused by medical conditions. For instance, depression and anxiety is sometimes linked to certain medical problems.
- **When you start or change medications:** Your doctors can help make sure that the medications you take can be safely used together.
- **Changes in health status:** If your health changes, your doctors need to know to see if you need to have any tests or changes to your medications.

Also, to ensure quality care, many insurance companies request that therapists at RNLF Counseling Services notify patients' primary care/family doctor when services begin. We must have your written permission to comply with this insurance company request. Please complete the Primary Care Physician Notification Form on the next page so we know if you wish to authorize us, or not authorize us, to notify your primary care/family doctor that you are receiving services at RNLF Counseling Services.

Primary Care Physician Notification Form

THIS IS NOT A REQUEST FOR MEDICAL RECORDS!

Attention Primary Care Physician: Your patient is being seen at RNLF Counseling Services. With patient authorization, we herein provide diagnoses and medications including medication changes. Please retain for your records.

Patient Name:_____

DSM-V/ICD-10-CM Codes:_____

_____

Treatment Information Including Medications:_____

_____

_____

_____

Therapist/Psychiatrist Signature

_____

Print Therapist/Psychiatrist Name and Credentials

TO THE PATIENT:

If you **do** wish us to notify your primary care/family doctor that you are receiving services, please provide the complete name and address of your Primary Care Physician:

Primary Care Physician:_____Phone_____

Clinic Name (If any):_____Fax:_____

Adress:_____

City, State, Zip:_____

Please read and complete the following:

I, (print name here)_____DOB:_____ hereby authorize RNLF Counseling Services to exchange information regarding my mental health and/or substance abuse treatment and medical health care for the purpose of continuity of care as may be necessary for the administration and provision of my health care coverage. Information exchanged may include information on mental health care or substance abuse treatment as protected under 42 CPR Part 2 (respecting substance abuse records) and/or state laws respecting confidentiality of records and patient communications with health care providers and in compliance with HIPAA regulations. I understand that this authorization shall remain in effect for one year or throughout the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the behavioral health care provider indicated herein. I also understand that it is my responsibility to notify my behavioral health care provider if I choose to change my primary care physician.

If you **do not** wish to authorize us to notify your primary care/family doctor, please complete the section below:
____I don't have a primary care/family doctor.
____I don't want my primary care/family doctor to know I am receiving services.
____I just don't want to.
____Other_____

_____ _____

Patient Signature (or Parent/Guardian if patient is a minor) Date

_____ _____

Witness Date