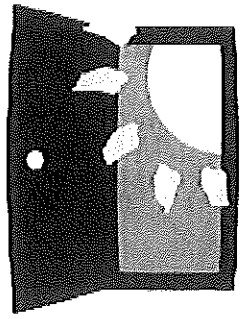

SPCS

SPENCER PSYCHIATRIC
& COUNSELING SERVICES

20 W 6th St. Ste. 306, PO Box 680, Spencer, IA 51301

Sharon Eckhart, ARNP, BC
Dawn Howley, ARNP, BC
Phone: 712-580-3882
FAX: 712-580-3932

Page Two of Patient Details

Patient Name:_____

D.O.B._____

I authorize the release of any medical or mental health information necessary to process this claim. I authorize payment of benefits to any and all providers of services rendered by SPCS.

X_____Date:_____
Patient/Guardian Signature

I authorize psychiatric care at SPCS. I permit the doctor, his/her employees and all other persons caring for me to treat me in ways they judge beneficial to me. I understand that this may include exams, tests, medical and/or psychiatric treatment.

X_____Date:_____
Patient/Guardian Signature

I authorize SPCS to leave messages on an answering machine or voice mail.

X _____ Date: _____
Patient/Guardian Signature

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Authorization for Use and **Disclosure** of Information for Purposes Requested by a Healthcare Office:

I, Patient Name--_____ DOB-_____

Authorize SPCS to: Use and/or disclose the following Protected Health Information to:

Agency--_____

__Psychiatric Evaluation___Psycho/Social Evalutaion___Substance Abuse___Medication Notes___Medication List___HIV/AIDS___Laboratory Results___Verbal and Written

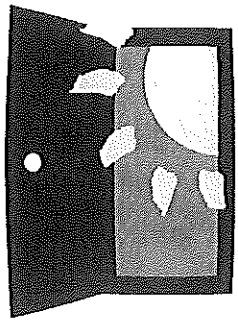
X------All of the Above

This Protected Health Information is being used or disclosed for the following purposes: Treatment, Continuity of Care, Collaboration, Referral and/or health care operations. This Authorization shall be in force and effect until 12 months from the date signed at which time this Authorization to use or disclosed this Protected Health Information expires. I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to SPCS 2016 Hwy Blvd. PO Box 680 Spencer, IA 51301. I understand that a revocation is not effective to the extent that SPCS has relied on the use or disclosure of the Protected Health Information. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. SPCS will not condition my treatment on whether I provide Authorization for the requested use or disclosure. I understand that I have the right to inspect or copy the Protected Health Information to be used or disclosed as permitted under federal or state law. I have the right to refuse to sign this Authorization. Confidentially of mental health information is protected by federal and state law, Chapter 228 of the Iowa Code and federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2 and cannot be disclosed without my written consent. Unauthorized disclosure may result in civil damages and criminal penalties.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative (PRINT) Patient SS Number

_____
Description of Personal Representative's Authority



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Authorization/**Request for Release** of Information for Purposes Requested by a Healthcare Office from another Covered Entity

I, Patient Name-_____DOB-_____

Hereby authorize, Agency--_____

To disclose the following Protected Health Information to SPCS:

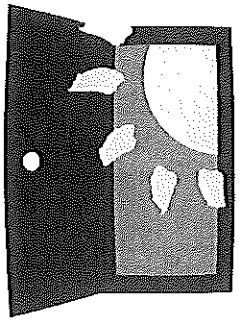
___Medical History/Exam ___Lab Results ___Substance Abuse ___Inpatient Records ___Progress Notes ___HIV/AIDS ___Psychological Reports ___Medication List ___Verbal and Written ___Social History ___Psychiatric Evaluation X - All of the Above Information.

This Protected Health Information is being used or disclosed to carry out treatment, continuity of care, collaboration, payment and/or health care operations of SPCS. This Authorization shall be in force and effect until 12 months from signature date at which time this authorization to use or disclose this Protected health Information expires. I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to SPCS at 2016 Highway Blvd. PO Box 680, Spencer, Iowa 51301. I understand that a revocation is not effective to the extent that SPCS has relied on the use or disclosure of the Protected Health information. It is SPCS policy not to disclose Protected Health Information received from another covered healthcare entity. SPCS will not condition my treatment, payment or enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide Authorization for the requested use or disclosure. I understand that I have the right to refuse to sign this Release. Confidentially of mental health information is protected by federal and state law, Chapter 228 of the Iowa code and federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2 and cannot be disclosed without my written consent. Unauthorized disclosure may result in civil damages and criminal penalties.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative (PRINT) Patient SS Number

_____
Description of Personal Representative's Authority



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AUTHORIZATION TO FAX Mental Health Information:

Patient's Name_____ Date of Birth_____

Previous Name:_____Soc Sec Number_____

I request and authorize_____SPCS _____to release mental health information by facsimile transmission to:

Name:

_____

Address:_____

City:_____State: _____Zip_____

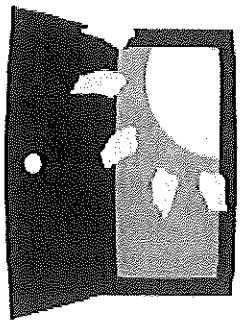
This request and authorization applies to:

----------All Mental Health Information

I understand and accept the risk of diminished security of Confidential Mental Health Information which is transmitted by FAX transmission due to misdirection of telephone communication. I understand that all due attention will be extended by staff of Spencer Psychiatric & Counseling Services, L.L.C., but that receipt only by the intended recipient can not be guaranteed. All FAX transmissions will be clearly identified as Confidential Mental Health Information protected by federal and state law.

This authorization is effective for all transmissions and expires one year after I no longer have had services at this facility.

Parent/Guardian/Patient Signature_____ Date_____



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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name(print):_____

Social Security Number:_____

Date of Birth:_____

I, the patient, acknowledge that the above-listed Spencer Psychiatric and Counseling Services, LLC has given me a copy of its Notice of Privacy Practices, which explains how my Protected Health Information will be used and disclosed in various situations.

_____ _____
Signature of patient or parent or legal guardian Date

_____
Printed name of patient

_____
Printed name of parent or legal guardian (if applicable)

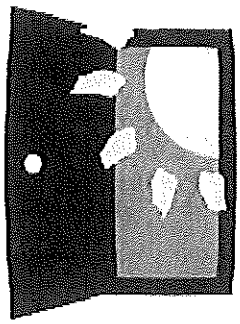
_____
Relationship to patient (if applicable)

For Clinician use only:
If unable to obtain acknowledgement, please document dates and circumstances of attempts below. Use the back of this sheet for additional documentation if necessary.

Date of attempt: _____

Circumstances prohibiting completion of Acknowledgement:

_____
_____
_____



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Patients Right and Responsibilities

Patient's Name: _____ Date of Birth: _____

Spencer Psychiatric & Counseling Services LLC is committed to treating patients in a manner that respects their rights. We recognize that each patient has the right to the following:

The right to receive information about your managed care organizations, its services, its practitioners and providers, and the patient's rights and responsibilities.

The right to be treated with respect and recognition of their dignity and right to privacy.

The right to participate with practitioners in decision making regarding their health care.

The right to full discussion of treatment options.

The right to voice complaints or appeals about the managed care organization of the care provided.

Each patient is responsible for cooperating with those providing health care services to the patient and shall have the following responsibilities.

The responsibility to provide, to the extent possible, information that the managed care organization and its practitioners and providers need in order to care for them.

The responsibility to follow the plans and instructions for care that they have agreed upon with their providers.

_____
Patient/Parent/Guardian Signature

Date-_____

I have an advanced psychiatric directive. Yes No