WISE MIND
PRACTICE

Name: DOB:

Authorizations and Advanced Directives:

***Authorization for Insurance Company Payment and Communication*:** I authorize necessary communication regarding confidential information between Morgan Kupsinel LISW IADC LIMHP and Wise Mind Practice and my insurance company.

Signature of client or responsible party *Date*

***Consent to Communicate with Primary Care Provider*:** Please choose one of the following:

- I do not give consent to communicate with my Primary Care Provider
- I give permission to communicate with my Primary Care Provider

Signature of client, parent or guardian *Date*

PCP Name _____ Office Location_____

Phone _____ Fax_____

***Psychiatric Advance Directives**:* Psychiatric advance directives are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

Although Iowa does not currently have a specific statute for a psychiatric advance directive, you can learn more about general advance directives for health care in Iowa at the caringinfo.org website.

Please check one of the following

- I have a psychiatric advance directive
- I do not have a psychiatric advance directive, however if I develop one I will give a copy to Wise Mind Practice LLC

I advise you seek legal counsel when developing a psychiatric advance directive.

Signature of client, parent or guardian *Date*