Monica A. Starr, APRN, LLC
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mstarraprn@gmail.com

Demographic Information

Name: _____

Home Address: _____ City: _____

Zip: _____ Birth Date: _____ Birth Place: _____

What is your preferred mode of communication?

Phone: _____ cell ☐work ☐home ☐ Email: _____

Can a detailed message be left with this mode of communication? Yes ☐ No ☐

Texting for confirmation of appointments? Yes ☐ No ☐

Employer: _____

IN CASE OF EMERGENCY NOTIFY

Full Name: _____ Relationship: _____

Business Phone: _____ Cell/Home Phone: _____

Consent for Care and Confidentiality Acknowledgement

I hereby authorize Monica A. Starr, APRN, LLC to provide psychiatric/mental health treatment and services. This authorization will remain in effect as long as I am a patient of the practice.

I consent to the use or disclosure of my protected health information by Monica A. Starr, APRN, LLC to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by Monica A. Starr, APRN, LLC may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with state and federal law, which may require specific written authorization. I understand that information regarding how Monica A. Starr, APRN, LLC will use and disclose my information can be found in Monica A. Starr, APRN, LLC's Notice of Privacy Practices. I understand that this consent is effective for as long as Monica A. Starr, APRN, LLC maintains my protected health Information.

By signing below, I understand and acknowledge the following:

- I have received a copy of the Privacy Practices and
- I understand this consent is in effect upon signing.

Signature: _____Date:_____

Updated 06/01/2014 by Monica A. Starr, APRN, LLC