

1320 South Frontage Road, Suite 200  
Hastings, MN 55033-2481  
651-500-0905  
651-437-2616 fax



2000 Old West Main Street, Suite 300  
Red Wing, MN 55066-1993  
651-500-0905  
651-212-6064 fax

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**Client's Name (print)**

HIPAA

I have read the Client Policy, HIPAA Information Form and Communications Policy. I understand my rights as a client of Tom Lutz and Associates and the limits of confidentiality. I also understand my financial responsibilities as a client.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. My signature means that I have read and understand the above mentioned documents.

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**Client or Client's Guardian**

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**Date**

Communication Policy

I consent to allow my therapist at Tom Lutz and Associates to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments.
- Information related to billing and payment.

I understand that I am not required to sign this agreement in order to receive treatment. I also understand I may terminate this consent at any time.

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**Client or Client's Guardian**

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**Date**

Assignment of Benefits

I hereby assign payment of insurance benefits to include major medical benefits to Tom Lutz and Associates and to release any medical information deemed necessary to secure payment. I understand that if I have insurance coverage, but do not give the necessary information needed for billing purposes, I will be responsible for 100% of the charges I incur.

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**Client or Client's Guardian**

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**Date**