Patient Name: _____

DOB: _____

CONSENT AND AUTHORIZATION FOR TREATMENT

CONSENT: I authorize personnel of Psych360, including physician and non-physician practitioners, to perform such examinations, therapeutic and diagnostic procedures, to administer such drugs, and to obtain such specimens as may be necessary or appropriate in the care and treatment of the patient identified above.I understand that services may be provided in a non traditional way through telemedicine (a computer system with a medical provider with you), through a virtual visit (a secure internet communication of face to face care through a specific application) or as part of a combination of telephone, internet and data sharing service.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION: I authorize Psych360 and its authorized personnel to use and disclose health information of the patient identified above for purposes of treatment, payment and health care operations and as otherwise permitted by applicable law.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize Psych360 to submit on my behalf claims for items and services furnished to the patient identified above to my health insurance plans, including Medicare and Medicaid. In consideration of the services provided to the patient identified above, I assign to Psych360 all rights to Medicare, Medicaid, and other insurance payments and benefits to which I may be entitled.

FINANCIAL RESPONSIBILITY: I understand that I (the patient) am responsible for payment of all charges for items and services furnished. I understand that insurance may not pay for all of the charges and I agree to pay all amounts not paid for by insurance.
I also agree to pay for any expense incurred by Psych360 in collecting the amounts I have agreed to pay, including all court costs, reasonable attorney's fees and all other collection expenses.

AUTHORIZATION TO USE PHOTO FOR HEALTH RECORD: I authorize personnel of Psych360 to take my photograph to be stored in my electronic health records for identification purposes.

REQUIRED

****Patient/POA Signature**:** _____

Patient/POA Name (Print): _____ Date: _____

REQUIRED

**** Witness Signature**:** _____

Witness Name (Print): _____ Date: _____

LEGAL REPRESENTATIVE SIGNATURE (as applicable)

By signing below, I certify that: (1) I am one of the following individuals; and (2) I am authorized to sign on the patient's behalf (check one):

__ Patient's legal guardian (42 C.F.R. §424.36(b)(1))
__ Relative or other person who receives Government benefits on the patient's behalf (42 C.F.R.§424.36(b)(2))
__ Relative or other person who arranges patient's treatment or manages the patient's affairs (42 C.F.R. §424.36(b)(3))

_____ _____ _____

Signature of Representative | Print Name of Representative | Date

Representative Email Address: _____

Representative Address: _____

Representative Phone Number: _____

This signature is not an acceptance of personal financial responsibility.