NEW HOPE PSYCHIATRY, LLC

PATIENT CONSENT FORM

Authorization for Medical Treatment, Statement of Financial Responsibility, Notice of Privacy Practices, Patient Rights and Responsibilities, and Magellan Member Rights and Responsibilities (if applicable)

Authorization for Medical Treatment – I authorize the healthcare providers and/or designees in charge of my medical care to administer any treatment as may be necessary or advisable in my diagnosis and treatment at New Hope Psychiatry, LLC. This authorization includes, but is not limited to, routine diagnostic procedures, psychotherapy, lab test, and the use of prescription medication. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatment received at this Practice.

Initial _____

Financial Agreement – I understand that I am financially responsible to the Practice as the patient, parent, guardian, conservator, or insured for all charges not covered by my insurance plan. The Practice will submit insurance claims on my behalf, however, I am responsible for all deductibles, co-insurance, out-of-pocket expenses, or any charges not covered by my insurance. My estimated share of cost will be due and collected at the time of service. In the event that payment cannot be made, a statement will be mailed and payable within 10 days of receipt. After 60 days, any unpaid balances may be turned over to a collection agency. Initial _____

Insurance Release of Information/Assignment of Benefits – I authorize New Hope Psychiatry, LLC to release to my Medicare carrier or the Insurance Plan listed previously, any medical information needed for authorization or payment of my insurance claim. I also authorize payments directly to this Practice for my health benefits. I understand that I am responsible for all pre-authorization requirements by my insurance. Initial _____

Notice of Privacy Practices – I have been given the opportunity to review the Practice's Notice of Privacy Practices for Protected Health Information. I understand that the Practice may change the Notice of Privacy Practices at any time and that I may obtain a current copy at the Practice during operating hours. Initial _____

Patient Rights and Responsibilities – I have been given the opportunity to review the Practice's Patient Rights and Responsibilities. Such Rights and Responsibilities may be changed at any time and I may obtain a current copy from the Practice during operating hours. Initial _____

Medicare patients ONLY: Medicaid Authorization - I request that payment of authorized Medicare benefits be made either to me, or, on my behalf, toNew Hope Psychiatry, LLC for any services furnished to me by their providers. I authorize my holder of medical information about me to release to the Centers for Medicaid and Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services. Initial_____

Medicare patients ONLY: Secondary Insurance Benefits Authorization - I hereby authorize payment of my Medigap and/or Secondary Insurance benefits to New Hope Psychiatry, LLC for all claims filed on my behalf. The authorization applies to all services until it is revoked by me or my representative. Initial _____

Pharmacy Health Information Exchange: I consent for New Hope Psychiatry, LLC to obtain my medication history electronically through a pharmacy health information exchange. New Hope Psychiatry, LLC may access the information to know what medications I am taking so that I can be properly and safely treated to avoid adverse drug interactions. Initial_____

Communication consent for: Reminder calls, texts, and emails - To assist with consistent appointment attendance, it is the practice of New Hope Psychiatry, LLC to utilize reminder phone calls, text messages, and emails. Patients may opt in or out of this service at any point. I understand that dependent upon my phone plan, I could be charged for these services. Initial_____

- ❑ **I consent to receive automated text messaging for appointment reminders**
- ❑ **I consent to receive automated emailed appointment reminders**
- ❑ **I chose to opt out of the following reminder options: (Please circle)**

PHONE CALL TEXT MESSAGE EMAIL

Patient Signature _____
Date_____

***If Parent/Guardian/Guarantor, please print patient's name here**

_____

***Parent/Guardian/Guarantor Signature** _____ **Date** _____