SHENANDOAH PSYCHIATRIC MEDICINE

19 BRIAR KNOLL CT. SUITE 1 **PHONE (540) 949 0955**
FISHERSVILLE, VA. 22939 **FAX (540) 949 8377**

PERMISSION TO TREAT

This is to inform you of some of the important expectations and responsibilities regarding your outpatient care at SHENANDOAH PSYCHIATRIC MEDICINE. After reading the form completely, please sign on the line below acknowledging your acceptance.

DUTY TO COOPERATE: As a patient seeking treatment, you have a duty to cooperate with your Clinician on your plan of care.
APPOINTMENTS: We request notice of cancellation 24 hours prior to the scheduled appointment. If you fail to keep or cancel appointments on frequent basis, your Clinician may have a discussion with you regarding your treatment plan.
CONSENT: I voluntarily consent to all treatment by SHENANDOAH PSYCHIATRIC MEDICINE, its agents, employees, and contractors as deemed necessary by my attending Clinician or his/her consultants, associates or designees, including but not limited to SHENANDOAH PSYCHIATRIC MEDICINE outpatient services.
NO GUARANTY OR WARRANTY: The practice of psychiatric medicine and diagnosis and treatment may involve risk. I acknowledge that no guarantees or warranties have been made regarding results of any evaluation and treatment.
PAYMENT FOR SERVICES: If you have insurance coverage, it is your responsibility to be knowledgeable and understand what your Insurance will cover and your expected financial responsibility. You should be certain to understand the process for obtaining referrals or preauthorization if required by your benefit design plan, the amount of patient pay amounts (co-payment, deductible, coinsurance), and any dollar or visit limitation. *Payment is expected at the time of your office visit for all charges if no insurance is to be billed or for your co-payments if the treatment is covered by insurance.* If you have questions regarding your financial obligation, please discuss these with your Clinician or the office staff.
ASSIGNMENT OF BENEFITS: In consideration of services rendered pursuant to this Consent whether during a single visit or on a continuing basis, I agree to pay full charges for services less any amounts paid by third party payors, and I hereby assign to SHENANDOAH PSYCHIATRIC MEDICINE to the extent necessary to satisfy any outstanding indebtedness, all sums payable to Patient pursuant to any health benefit plan, policy of insurance (including health, liability, uninsured, under-insured, motorist or medical payments insurance) and/or pursuant to any settlement or judgment arising out of or related to any incident which caused this treatment rendered pursuant to this Consent. I understand that I am financially responsible to SHENANDOAH PSYCHIATRIC MEDICINE for all its charges not covered by a third party source, except as agreed between SHENANDOAH PSYCHIATRIC MEDICINE and any third party source.
MEDICARE PATIENTS: If I (Patient) am a Medicare patient, I request that payment be made on my behalf, and I assign the benefits payable for services furnished to me (Patient) by or in SHENANDOAH PSYCHIATRIC MEDICINE, including Clinician services, to the Clinicians furnishing the services, to submit a claim to Medicare for payment for me. I understand that I am responsible for any deductibles and the applicable percentages of the reasonable charges. I authorize any holder of medical or other information about me (Patient) to release to the Social Security Administration or its intermediaries or carriers any information needed for this/related Medicare/Medicaid claim.
CONFIDENTIALITY: The patient information will be maintained in accordance with applicable federal and state laws, rules, or regulations, which authorize disclosure in certain circumstances including but not limited to the following.

i. *In the case of child or dependent adult abuse or neglect*
ii. *In the case of insurance companies as required for billing and payment*
iii. *In the case of survey requirements of accreditation and licensure agencies*
iv. *In the case of subpoenas or court orders*
v. *In the case of any collection proceedings, if necessary*
vi. *In the case of any circumstances where disclosure is permitted or required pursuant to applicable federal or state laws, rules, and regulations.*

_____ _____ _____ _____
Signature Of Patient/Responsible Party *Relationship* *Witness* *Date*