Family Psychiatric Center LLC

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

All information between counselor and patient is held strictly confidential unless:

- The patient authorizes release of information with his/her signature.
- The patient presents a physical danger to self or others.
- Child/elder abuse/neglect are suspected.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

APPEALS AND GRIEVANCES

I understand that I have a right to request reconsideration in the case that outpatient care is not authorized. (Appeal) I understand that the request for appeal can be made through my Provider Health Plan that I risk nothing in exercising that right.

I also understand that I have to submit a complain/grievance and risk nothing to exercise that right. I understand that to submit a complaint or grievance, I may contact the Service department of my Health Plan.

CONSENT FOR TREATMENT

I further authorize and request _____ carry out Mental Health/Psychological
(Name of Provider)
treatments and/or diagnostic procedures which now or during the course of my care as a patient at advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may, at time, be difficult and uncomfortable.

I understand that I am consenting and agreeing only to those mental health services that the above named provider is qualified to provide within:

A. The scope of the provider's license, certification, and training; or
B. The scope of license, certification, and training of those mental health providers directly supervising the services received by the patient.

RELEASE OF INFORMATION

I authorize the release of information for claims, certification/case management/quality improvement and other purposes related to benefits of my Health Plan. (Release of information to other providers, family, etc. requires separate forms.)

I understand and agree to all of the above information.

_____ _____
Print Patient Name Signature

_____ _____ _____
Relationship to patient Date Witness