CLIENT'S CONSENT TO EXCHANGE INFORMATION

PRIMARY CARE PHYSICIAN

Insurance plans and managed care organizations encourage the exchange of information between this office and your Primary Care Physician (PCP) in order to coordinate medical and psychiatric care. A letter may be sent to your:

PCP/Referring Physician/Pediatrician_____

located at_____,

to exchange information regarding your medical and psychiatric care with no limitations placed on dates, history of illness or diagnostic and therapeutic information, including treatment for drug and/or alcohol abuse.

_____ **I do not want information sent to my PCP/Pediatrician**
Initial

INSURANCE CLAIMS PAYMENT

I authorize the release of medical record information or excerpts thereof, to any insurance company or third party payor for utilization management, audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

_____ **I do not want information sent to my insurance company and agree to be personally responsible for all charges.**
Initial

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to pay Tucker Psychiatric Clinic (TPC) its usual charges for all services received, including any balances not covered by my insurance carrier(s). I understand that it is the patient's responsibility to obtain any prior authorization or doctor's referral. I understand that failure to meet this requirement may result in a significant loss of benefits. I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to TPC, and direct that payment of proceeds be made directly to TPC. Because we reserve your appointment time for you, we charge a fee up to and including our full normal fee, for missed appointments not cancelled at least 24 hours in advance.

My signature below represents that I have read and understand the terms and statements above.

This consent and authorization form will remain in effect for the duration of my treatment unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this consent and authorization form is to be considered as valid as an original.

_____ _____
Patient's Signature Date

_____ _____
Parent/Guardian's Signature Date

I have witnessed the completion of this authorization form.

_____ _____
Employee Signature Date

Acknowledgement of Notice of Privacy Practices

I have received a copy of the Tucker Psychiatric Notice of Privacy Practices. I understand that I may ask questions to Tucker Psychiatric if I do not understand any information contained in the Notice of Privacy Practices.

_____ _____
Patient/Guardian's Signature Date

Third Party Access

I authorize Tucker Psychiatric to disclose current healthcare information with the family/others listed below.

_____ _____
Spouse Parent

_____ _____
Sibling Other

_____ _____
Patient Signature Date Employee Signature Date