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Empowering Minds Behavioral Health PLLC Consent for Services and Treatment

1. I _____ (patient over 14/guardian's name) give permission for provider(s) at Empowering Minds Behavioral Health PLLC to give me/my child psychiatric and medication treatment. I am providing informed consent, meaning that I have thoroughly discussed the risk and benefits of treatment with the provider today and choose to continue treatment with the provider.
2. I allow Empowering Minds Behavioral Health PLLC Provider(s) to submit claims to insurance on my behalf to pay for the care I receive if no agreement for cash payment has been made.
3. I understand that Empowering Minds Behavioral Health PLLC provider/staff will have to send my protected health information (PHI) to my insurance company if that is the method of payment agreed upon. PHI may be shared without authorization in cases of emergency, child or elderly abuse, serious threats of self-harm or harm to others, and for certain legal matters.
4. I must pay my share of costs if my insurance fails to pay the minimum cash price.
5. I must pay for the cost of these services if my insurance does not pay, or I do not have insurance.
6. I have the right to refuse treatment or psychotropic medication management .
7. I have the right to discuss all mental health treatment with the provider.
8. I understand that my provider has the right to prescribe or NOT prescribe any medication as provider sees clinically appropriate.
9. I understand that all patients, excluding patients that have secondary medical assistance, are required to keep a credit card on file.
10. I understand that payment of services, including any co-pays/deductibles/co-insurance, is due at the time of visit. I understand that **I will owe $100 for missed appointments or cancelations with less that 48 business hours' notice**. I understand I will owe this amount **out of pocket.** I understand that I may be terminated as a client for missed appointments and/or multiple cancelled appointments.
11. I understand that I have been informed of the self-pay- rates, which are flat fees. I will be notified ahead of time prior to any increase in rates.
12. I have received the notice of privacy practices and how to access more information on HIPAA.
13. I understand that Empowering Minds Behavioral Health PLLC will not disclose any information about me or my treatment here, without my written consent. However, there are exceptions to this which include but are not limited to insurance companies, legal, and/or ethical obligations of the provider/staff.
14. I understand that Empowering Minds Behavioral Health PLLC does **not** provide any emergency care and that I am to call **911** if I need emergency care.
15. I understand that I may be terminated as a client of Empowering Minds Behavioral Health PLLC at any time, for any reason, that my provider sees as appropriate and that I may terminate my care with Empowering Minds Behavioral Health PLLC at any time.

Upon termination, I understand that I may be given no more than a 90 -day supply of medication refills.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature Date
(For children under 14 years)

_____ _____

Print Name Date