

Outpatient Informed Consent and Treatment Authorization

Please read this document carefully. It contains important information about our professional services, business policies, and your rights and responsibilities as a patient. By filling in the information below and signing this document, you authorize outpatient treatment and agree to the terms outlined herein.

1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Home Address:

Emergency Contact Name & Relationship:

Emergency Contact Phone Number:

2. Consent for Treatment

I hereby request and consent to receive outpatient evaluation, therapeutic services, and/or medical treatment as deemed necessary and advisable by my healthcare provider. I understand that the practice of medicine and psychotherapy is not an exact science and that no guarantees have been made to me as to the results of evaluation or treatment.

I acknowledge that I have the right to discuss the treatment plan, alternative procedures, and the risks and benefits associated with outpatient care with my provider at any time during my course of treatment.

3. Financial Responsibility and Insurance Authorization

I understand and agree that I am ultimately responsible for all charges associated with the services provided to me. If I am using health insurance, I authorize the release of any medical or other information necessary to process claims. I also authorize payment of medical benefits directly to the provider/clinic.

I understand that I am responsible for paying any co-payments, deductibles, or non-covered services at the time of service or upon billing.

4. Privacy Practices (HIPAA)

I acknowledge that I have been provided access to or a copy of the Notice of Privacy Practices. This notice describes how my protected health information (PHI) may be used and disclosed, and how I can gain access to this information. I understand my rights regarding my private health records.

5. Cancellation and Late Policy

I agree to provide at least 24 hours' notice for any appointment cancellations. I understand that failure to provide adequate notice or failure to show up for a scheduled appointment may result in a late cancellation or no-show fee that is not covered by insurance.

6. Patient Acknowledgment and Signature

By signing below, I acknowledge that I have read, understood, and voluntarily agree to the terms of this Outpatient Informed Consent and Treatment Authorization.

Name of Parent or Legal Guardian (if patient is a minor):

Patient or Guardian Signature (Type name to sign electronically):

Date (MM/DD/YYYY):

7. Clinician / Witness Acknowledgment

Provider / Witness Name:

Provider / Witness Signature:

Date (MM/DD/YYYY):