CONSENT FOR EVALUATION AND/OR TREATMENT AND TO USE AND DISCLOSE PATIENT HEALTH INFORMATION

I voluntarily apply for evaluation and/or treatment at the office of Elizabeth A McMorran, NP and understand, consent and agree as follows (to be executed by legally authorized person if patient incapable or below age of legal consent to execute informed consent):

1. I have been provided with the intended outcome, nature and procedures involved in the proposed treatment. I have entered into a discussion of side effects (if any) of treatment or lack of treatment as well as alternatives to the proposed treatment. **I understand that consent may be withdrawn at any time with no punitive action taken.**
2. Information developed as part of the evaluation/treatment and any psychiatric records are confidential but may be released to those parties as required by law in cases of medical emergency, abuse or neglect, court order, insurance billing claims requirements, audit and where otherwise legally required. I understand that a properly executed consent for release of information form is required in all other situations. I understand that some insurance companies and managed care companies require disclose to the primary care provider.
3. I consent to the use and disclosure of my protected health information as outlined in the Notice of Privacy Practices as noted in HIPAA: 45 CFR 160-164 for the purpose of treatment, payment and health care operations. I have the right to review the Notice of Privacy Practices (attached) prior to signing this consent. The Notice may be changed at any time. The Notice also describes my rights with respect to the use and disclose of my private health information (PHI).
4. I understand that psychiatric medication, if prescribed, may or may not be effective. In a small number of situations, I may experience adverse reactions to such medication and it is my responsibility to keep the prescriber informed of any medication effects. The risks and benefits of any prescription medications will be explained and discussed with me throughout my treatment.
5. I have received a copy of the Welcome Letter with the policies of this office. Our insurance contracts require us to collect deductibles and co-pays at the time of service.
6. A parent or guardian **must** accompany a minor patient to his visits unless other arrangements have been made **in advance.** The adult accompanying the minor patient is responsible for payment for services at the time of the visit.

I have read the above policies. I understand and agree to the financial and Privacy Policies.

X_____

Signature of Patient/Legal Guardian/Responsible Party Date