

PATIENT CONSENT FOR TREATMENT

Grover MD Psychiatry
322 E Gateway Drive Suite 102
Heber City, UT 84032
Phone: (801) 747- 9551
Fax: (801) 810- 1396
Douglas@www.grovermdpsychiatry.com

1. I voluntarily consent to all health care treatment and diagnostic procedures provided by Grover MD Psychiatry. I am aware that the practice of medicine, especially Psychiatry, is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations provided by Grover MD Psychiatry.
2. I consent to the use and disclosure of my protected health information for purposes of obtaining payment for services rendered to me, treatment, and health care operations consistent with both the Notice of Privacy Practices and Payment Policy provided by Grover MD Psychiatry.
3. I have either received a copy of the Notice of Privacy Practice or I have been provided easy access to the Notice of Privacy Practice and I agree with its contents.
4. I have either received a copy of the Payment Policy or I have been provided easy access to the Payment Policy and I agree with its contents.
5. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

By signing your name below, you confirm you have reviewed each of the above statements, understand the contents of each of the above statements, and agree to each of the above statements.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)