Medical Group

Treatment Consent & Patient Confidentiality

EMERGENCIES: If you have a life threatening emergency situation, please call 911 or go to your nearest hospital emergency room. If you have an emergency, please call 818-500-9709 and you physician will be paged.

The purpose of this information sheet is to acquaint you with our office policies and procedures. Refer to the "Notice of Privacy Practices" located in our waiting area for a more complete explanation. The following policies outline the uses and disclosures of your Protected Health Information (PHI). Brand Psychiatric Medical Group is referred to as BPMG in the following information.

My INITIALS in the boxes and SIGNATURE below indicate that I have read and understand the following procedures.

INITIAL BELOW	FORM TO BE COMPLETED BY PATIENT (OR PARENT / GUARDIAN IF PATIENT IS UNDER THE AGE OF 18)
G.G. INITIALS	**Confidentiality:** To protect your best interests and personal rights, please be aware that professional ethics and law dictate whatever you say to your psychotherapist or doctor (your Protected Health Information or PHI) will remain confidential and will not be shared with anyone without your written permission. The following are exceptions to this confidentiality and may be clarified with your Practitioner. 1. If you indicate that you intend to harm yourself or anyone else your Practitioner must take reasonable and precautionary measures to protect whoever is in danger. 2. If you report to your Practitioner any knowledge of child, elder, or dependent abuse, your Practitioner may be required by law to report it to the authorities or child protective services. 3. If you are under the age of 18, your parents or legal guardians have the right to be informed of your psychological condition, progress, and treatment goals. 4. Brief written records are kept regarding your treatment goals and progress. Certain situations may arise where the records are subpoenaed by a judge. We may be compelled to surrender them. This may occur when you become involved in a legal situation in which your psychological state is an issue.
G.G. INITIALS	**Consent for Treatment:** I authorize treatment for myself or the dependent indicated as the patient. 1. I understand my Practitioner will discuss my individual treatment with me; together we will revise my treatment plan as necessary. 2. I authorize my behavioral health Practitioner to carry out psychological examinations, treatment, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. 3. I understand that while the course of my treatment is designed to be helpful, it may at times be difficult and uncomfortable.
G.G. INITIALS	**Release of Information to the Health Plan:** I understand that if my behavioral healthcare Practitioner requests authorization for additional sessions from my managed care company, the medical necessity for further treatment and the effectiveness of treatment already provided will be weighed. 1. I authorize BPMG to release the required information in order to process claims with my payor. I authorize payment of psychological / mental health and hospital benefits to BPMG for the professional services rendered.
G.G. INITIALS	**Coordination of Care between BPMG Practitioners:** If I am under treatment with more than one BPMG Practitioner, I authorize communication regarding my treatment between my BPMG Practitioners.
G.G. INITIALS	**Courtesy Call:** I authorize my healthcare provider to use an automated telephone system and to use my name, the name of my scheduled treating healthcare provider, and the time of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited PHI regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine. I understand that a call to remind me of an appointment is only a courtesy provided by BPMG and that any failure by the automated phone system to provide the courtesy call does not relieve me of my responsibility to either keep my appointment or cancel within 24 hours.
G.G. INITIALS	**Release of my Protected Health Information:** I authorize my behavioral healthcare Practitioner to communicate the above-mentioned PHI, in accordance with my "Notice of Privacy Practices", in person, by telephone, by written material, e-mail, or by facsimile. I understand that BPMG cannot be held responsible for maintaining confidentiality once my PHI leaves the office. I release the source of these records from any liability arising from their release.
G.G. INITIALS	**Appeals and Grievances:** I understand that I have the right to formally appeal decisions regarding authorized treatment services by first contacting BPMG. I further understand that I have the right to submit a complaint or grievance to BPMG regarding any aspect of my care, or I may submit complaints to my health plan. I understand that I risk nothing in exercising these rights.
G.G. INITIALS	**Revocation of Consent:** I understand that this authorization is subject to revocation by me at any time except to the extent that action has been taken in reliance hereon and that a photocopy of this release is to be considered as valid as the original.
G.G. INITIALS	**I hereby acknowledge that I have been provided a copy of BPMG Psychiatric Medical Group's "Notice of Privacy Practices". See P. 1 of this packet.**

I understand and agree to the above:

Patient / Legal Guardian (please print): SYLVIA SCHMITD / Gertrude Gettinger

Patient / Legal Guardian Signature: _____ **Date:** 21. III. 2007

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Brand Psychiatric Medical Group

Financial Agreement

FINANCIAL RESPONSIBILITIES

All professional services provided are charged to the patient or legal guardian unless there is an agreement with a third party payor (health plan, medical group, union, etc.).

1. Patients are personally responsible for co-payments, co-insurance, deductibles, percentages of charges when required by health plan, and/or all charges incurred if insurance coverage terminates or changes during the course of treatment.
2. Co-payments or other amounts for which the patient is responsible are due at the time of service.
3. If a check is returned by the bank, a fee of **$15.00** is added to the patient's account.
4. The patient is expected to know the amount of his or her financial responsibility regarding co-payments and other patient payments. Patients can call the number on the insurance card for this information.
5. If the incorrect co-payment or other patient payment is made, the difference will be indicated on the third party payor Explanation of Benefits. The patient is responsible for any underpayment and this amount will be added to his or her account. In the event of an over-payment, this amount will be deducted from the patient's account or future co-payment(s).
6. The patient will be billed **$55.00** for a missed or late cancellation of a medication management (15 minute) appointment with a psychiatrist and **$60.00** for a missed or late cancellation of a psychotherapy (45 minute) appointment with a licensed therapist.
7. In the event a patient's overdue account must be submitted to a collection agency or legal action should become necessary to collect any unpaid balance, the patient is responsible for collection, attorney, and court costs.
8. A copy of this assignment is as valid as the original.

I have read the above information and agree to accept the financial responsibilities for myself or for the dependent, if I am the legal representative.

Gertrude Gettinger
Patient / Responsible Party Signature

March 21, 2007
Date

Patient's Printed Name

Patient Social Security Number

Brand Psychiatric
Medical Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided a copy of the current NOTICE OF PRIVACY PRACTICES for:

Gertrude Gettinger
Signature of Patient/Guardian

Date: 21 March 2007

H.S.

Printed Name of Patient/Guardian

Staff/Clinician's Signature

STAFF USE ONLY:

If the NOTICE OF PRIVACY PRACTICES was not given to the patient or the patient's legal representative, please indicate why not below.

Date

Staff/ Clinicians Signature