Consents and Authorizations

Treatment and Policy Consents

1. I have the legal right to authorize and I hereby consent for services for myself or my dependent at PRA to include evaluation, psychotherapy, testing (if indicated), medication management or group therapy.
2. I authorize communication within the PRA treatment team which includes your psychiatrist and therapist, covering clinicians and office personnel in order to provide comprehensive treatment services.
3. When paging a PRA MD or therapist, please turn off any privacy manager features you may have on your phone so they may return your call promptly. I understand that my failure to turn off privacy manager features or not leaving a clear phone number for my MD/therapist may result in a delay or inability for my clinician to respond. In addition, MD/therapist voicemails will guide you on how to page your clinician. Please follow the guidelines and instructions on your clinicians' voicemail to page them for urgent needs.
4. I understand that appointments not canceled at least 24 hours in advance will be billed to the patient at the session rate and cannot be billed to, nor reimbursed by insurance (even if our office has a contract with your insurance company).
5. I understand that follow up treatment is required to maintain ongoing quality care. PRA MD's require follow up every three months. Failure to follow up with your psychiatrist on the recommended basis will result in prescription refills being denied. Failure to follow up longer than a 6 months period of time with either one of our psychiatrists or your therapist will automatically result in your case becoming inactive with our practice, requiring a new evaluation should you wish to be seen by one of our clinicians again and the clinician is willing to reopen your case.
6. I understand that clinicians at PRA may refer me or my family member to clinicians or services outside of the practice if they feel their level of expertise or PRA is not the most appropriate treatment option. I understand that clinicians are ethically bound to refer out if they feel they can no longer effectively treat me or my family member and will refer to another agency, facility or program that can better meet your clinical needs.
7. Our website is available for general information services only and PRA **DOES NOT** use email or our website for patients to communicate clinical, urgent and other appointment related concerns or needs. I understand that I must contact PRA by phone for all patient clinical, urgent or administrative concerns as the website is for general information only and not meant for communicating clinical issues or emergencies.
8. I have received a copy of PRA's Notice of Privacy Practices and understand and agree to my responsibilities as a patient receiving services from the named PRA provider listed on the Client Information Form.

Financial Consents/Authorizations

A. I have completed the demographic and insurance information on the Client Information Form to the best of my knowledge and authorize PRA to release any medical information (including types of services, dates/times of services, diagnosis along with treatment plans, progress of treatment, case notes and summaries, if necessary) to process my insurance claim(s).

B. As a courtesy to our patients, we attempt to contact your insurance company to obtain benefit information for your care here at PRA. Benefit results given to patients by our office is not a guarantee of payment by your insurer. I understand that benefits obtained by PRA office staff are estimates based on information given to us by your insurance company.

C. I hereby assign all medical, including Major Medical benefits to which I am entitled, private insurance and any other insurance programs to PRA. A photocopy of this assignment is to be considered as valid as original. This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges, whether or not paid by said insurance and that I will be responsible for any amounts uncollected by PRA. In addition, I understand that failure to keep current with payments may cause an interruption in treatment services until a payment plan or balance due is paid. In addition, I agree to inform PRA of any contact or insurance information changes promptly. Failure to do so may result in claims not being filed timely with your new insurance company resulting in the responsible party being liable for any amounts unpaid by the insurance company.

D. You will be provided with all the required documentation to file claims with your insurance company. If we have a contract with your insurance company, our office will bill your insurance company for the provider portion; however; any deductibles, co-pays and/or applicable fees are due at the time of your office visit. We accept Cash, Checks and Credit Cards (Visa, MasterCard and Discover). We do not have the ability to make change for cash. The office charges a $25 return check fee for any checks returned to our office by our bank.

E. For patients under 18 years of age – If you are a parent and are unable to accompany your child who is a patient to the appointment, please send them with a check or we can put a credit card number on file. If there is a divorce agreement between parents on financial responsibility the parent that accompanies the patient is responsible for making the co-payment at the time of service. I understand that PRA is not responsible for upholding the agreements made between parents in divorce situations.

F. If fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. Our office will charge a 30% administrative/collection fee should your account be turned over to our collection agency. I authorize PRA to release any basic financial and demographic information necessary to PRA's contracted collection agency in order to collect payment for services rendered as necessary.

For more detailed Policy and Procedures, please see our website at www.prapsych.com.

I have read, understood, and agree to the consents and authorizations above regarding my responsibilities as a patient receiving services from clinicians at PRA.

_____ ____/____/____ _____ ____/____/____

Signature of Patient (age 12 and older) Date Signature of Responsible Party (if different than patient) Date

_____ _____ ____/____/____

Print Patient's Name Witness Date

_____

Your MD/Therapist's Name

7/2010

White Copy: Therapist/MD file **Yellow Copy: Billing** **Pink Copy: Patient Copy**