AUTHORIZATIONS AND CONSENTS

Patient Name: _____ Guardian Name (If Applicable):_____

1. ***Authorization for Release of Information for Insurance Submission and Payment***

If you wish to have our office file your insurance, please present your insurance card. Some companies pay fixed allowances for treatment and others pay a percentage of the charge. **It is your responsibility to pay for any deductible amount, co-pay, any non-covered service, or service in which you are ineligible.** You are responsible for obtaining prior authorization for treatment from your insurance carrier. Failure to obtain authorization may result in increased financial expenses for your services. Authorization of service and payment by the insurance company is contingent on eligibility (at time of service) and benefits available. It is your responsibility to pay co-pay's at each visit. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits directly to the therapist or group indicated on the claim. I hereby authorize release of information (including diagnosis) necessary for treatment and processing of claims for insurance reimbursement. **I understand I am financially responsible for any balance not covered by my insurance.**

X_____ _____

Signature of Consumer/Legal Guardian/Legal Representative Date

2. ***Authorization to Release Information to PCP***

Communication between behavioral health providers and your primary care physician is important to ensure that you receive comprehensive and quality health care. I hereby authorize North Atlanta Psychiatry to release of my protected health information related to my evaluation and treatment to my primary care physician (PCP). I understand this information may include diagnosis, treatment plan, progress and medication information if necessary. I understand that I may revoke this consent in writing at any time except to the extent that it has been relied upon.

X_____ _____

Signature of Consumer/Legal Guardian/Legal Representative Date

3. ***Failed Appointments***

I agree to notify North Atlanta Psychiatry at least twenty-four (24) hours prior to my scheduled appointment if I decide to cancel/change. I understand I will be charged a fee of $40.00 for an appointment not kept or cancelled at least 24 hours in advance. I also understand that this charge is not the co-pay amount and is not reimbursable by my insurance.

X_____ _____

Signature of Consumer/Legal Guardian/Legal Representative Date

Patient Name: _____ Guardian Name (If Applicable):_____

4. ***Consent for Treatment Authorization***

I authorize and request North Atlanta Psychiatry to carry out psychological evaluations, psychiatric evaluations, treatment and/or diagnostic procedures that now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my behavioral healthcare professional can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that reactions will be worked on between my behavioral healthcare professional and me. With these understandings, I hereby authorize treatment for myself. I give permission for the Clinical Staff to develop a treatment plan and provide treatment. This consent is valid for each visit I make to North Atlanta Psychiatry, unless and until revoked by me in writing.

X_____ _____

Signature of Consumer/Legal Guardian/Legal Representative Date

5. ***Behavioral Health Orientation***

I have been provided an "Orientation to North Atlanta Psychiatry Services, Policies, and Procedures" packet which details policies and procedures. I have read the preceding information and have been given the opportunity to ask questions and agree to abide by these policies. I am also provided with Privacy policy of North Atlanta Psychiatry Services.

X_____ _____

Signature of Consumer/Legal Guardian/Legal Representative Date

6. ***Consent for Telephone contact***

I authorize that messages may be left for me regarding appointment reminders or instructions regarding my on

_____ My home answering machine
Initial
_____ My work answering machine
Initial
_____ My cell answering machine
Initial
_____My spouse/other family member
Initial

X_____ _____

Signature of Consumer/Legal Guardian/Legal Representative Date