Consent For Treatment

Thank you for choosing **Colorado Psychiatry Center, PC** (CPC), where caring for children, adolescents and adults is what we do. We consider families to be an essential participant in yours and your child's care and wish to support and respect your needs while your son, daughter or yourself is here. We want you to understand your rights and responsibilities as families and patients at CPC. Your signature on this form provides consent for treatment, payment, and acknowledges CPC office policies and receipt of other general information. If you have questions about any of policies, please contact us at 303-920-5161.

Consent for Treatment: I consent to and authorize the attending physician, physician's assistant, referring providers and others of the healthcare team, including providers in training, and students in other disciplines - to perform healthcare examinations, treatment, diagnostic testing, transfers and transportation as deemed medically necessary in their professional judgment.

Consent for Medical Photographs, Recording or Filming: I hereby grant permission for taking of photographs – for identification purposes, recording or filming for medical and training purposes as requested by my care-providers.

Research: I hereby grant permission to use my medical chart in a de-identified fashion to study the efficacy and safety of interventions used in my care. No information identifying me will be released without my express consent.

Expert Witness Rates/Fees: Our practice does NOT provide expert testimony. If CPC is compelled to testify in this capacity for you, you agree to pay CPC $1,000/hour with a two hour minimum deposit.

Assignment of Benefits and Release of Information

- I agree to be responsible for my co-payments, deductibles or other charges of CPC and of providers rendering services not covered or paid by insurance or other third party payers – except as prohibited by any agreement between my insurance company and CPC or by state or federal law.
- I authorize CPC to file any claims for payment of any portion of the patient bills and assign all rights and benefits payable for provider services to the provider or organization furnishing the services.
- I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses, delinquent charges and interest in the event CPC has to take action to collect same because of my failure to pay in full all incurred charges within 60 days after receipt of the bill.
- The term of this consent will be until final payments are made for any and all services.
- If and when there are changes to my insurance plans, I will notify CPC staff immediately.

Cancellation and Late Policy

___ I agree that:

- If I do not show up, or cancel my appointment with less than 24 hours notice that I will be charged $115.00 **automatically** through the credit card I have on file.
- I will need to keep a credit card on file so that in case I do not show up, or cancel my appointment with less than 24 hours notice I can be charged automatically. I understand that my card will be kept on file for this reason only.
- If I do not show up for an appointment or late cancel 2 or more times that I will be released from CPC care.
- I will arrive 10 minutes early for "check in" and Vitals. If I arrive late for an appointment that it will be rescheduled and considered a late cancel.

Billing Policy

___ I agree that: If I have an outstanding balance, I will be required to pay this balance in full before scheduling any future appointments and will help CPC to resolve any issues with my insurance company.

General Information

___ I understand:

- CPC may prescribe medication and require that the patient takes the medication as recommended.
- The first appointment is approximately one hour. All subsequent "follow-up" visits are intended to provide a brief checkup on the patient's status and to adjust or refill prescriptions. I will review the number of pills the patient has left before coming to the office.
- CPC will give me a list of recommended therapists if they feel it is appropriate, which they expect the patient to see on a regular basis.
- This form may not be altered. If this form is signed, the guardian or patient is agreeing to the original form in its entirety.

Disability

___ I understand: Our practice does NOT evaluate patients for disability. There are doctors in the community specially trained to evaluate disability. We do not have this training and cannot, in good conscience, evaluate people for benefits as we are not trained to do so.

Notice of Privacy Practices

___ I acknowledge the receipt of CPC's "Notice of Privacy Practices" brochure.

_____ _____ _____

Print Patient's Name | Guardian's Printed Name/Relationship (if applicable) | Date

_____

Patient Address | City/State/Zip

_____ _____ _____

Emergency Contact Name | Emergency Contact Phone | Patient Signature (Guardian Signature if under 18)

_____

CPC Staff Witness Signature and Date