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**Consent and Acknowledgment Form**

Welcome to Healthy Life Solutions. This document contains important information about our services and business policies. We can discuss any questions you have at any time.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Responsible Party Initials \_\_\_\_\_\_

Consent for Mental Health Services: Patients must give voluntary consent for mental health treatment. Your signature (or that of your legal guardian) will demonstrate consent for receiving mental health treatment from Healthy Life Solutions. I voluntarily consent to mental health treatment as performed by Healthy Life Solutions and its employees. This treatment may include but not limited to: assessment, screening, consultation and recommendations, psychotherapy, holistic services and psychiatric medication management. I understand that mental health treatment may involve certain risks and benefits and I understand these risks and benefits. I also understand the risks and benefits of declining treatment. I am also aware that I have the right to request information about alternative treatment options, should they exist. I have read the above information and I authorize Healthy Life Solutions to provide mental health services to myself or this patient (if guardian).

Patient or Responsible Party Initials \_\_\_\_\_\_

Authorization to Release: I hereby authorize Healthy Life Solutions and any provider caring for me to release or disclose to insurance companies and / or outpatient benefit programs and their designees all information from my medical record pertaining to my medical treatment as needed to process insurance claims.

Patient or Responsible Party Initials \_\_\_\_\_\_

Communication: I hereby authorize Healthy Life Solutions to communicate with me via voice mail in the event I cannot be reached directly. The phone number on which a voice mail may be left is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Patient or Responsible Party Initials \_\_\_\_\_\_

Release from Responsibility: If I should leave the clinic against medical advice or prior to treatment being completed, I hereby relieve said nurse practitioner, therapists and the clinic of all liability for my action.

Guarantee: Healthy Life Solutions is a fee-for-service mental health practice that strives to provide immediate care for patients needing its' services. I understand that I must pay for these services on the date care is rendered. I understand that Healthy Life Solutions will file services under my insurance.

Patient or Responsible Party Initials \_\_\_\_\_\_

Fee Schedule:

Initial Appointment with Psychiatric Nurse Practitioner $275

Follow-up Medication Management $175

Initial Assessment Individual Therapy Session $225

Follow-up Individual Therapy Session $200

Patient or Responsible Party Initials \_\_\_\_\_\_

Assignment of Benefits: I request that any payment of authorized benefits for which I am entitled and which are otherwise payable to me and related to this claim be made on my behalf directly to Healthy Life Solutions.

Patient or Responsible Party Initials \_\_\_\_\_\_

Cancellation / No Show Policy: If you will arrive 15 minutes past your scheduled time, please call. Patients who no-show or cancel two (2) or more times without 24-hour notice may be required to secure next appointment with a credit/debit card or be dismissed from the practice and thus they will be denied any future appointment(s). **Our fee to be charged to you for cancellation/no show is $50.00 and you will be required to pay this fee before another appointment will be made.**

Payment Terms: I understand that payment in full is due on the date of treatment for all services provided, and I agree to pay all charges for the patient named below. If payment in full is delayed for any reason (such as the failure of my insurance to pay the balance in full), I agree to pay the full balance.

Patient or Responsible Party Initials \_\_\_\_\_\_

Patient or Responsible Party Initials \_\_\_\_\_\_

Acknowledgment of Receipt of Notice of Privacy Practices: I hereby acknowledge that I have received, read and had an opportunity to ask questions concerning Healthy Life Solutions' Notice of Privacy Practices.

Consent to obtain patient medication history from my pharmacy, my health plans, and my other healthcare providers. Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the electronic medical record and becomes part of your personal chart. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous interactions. It is important for you and your provider to discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Patient or Responsible Party Initials \_\_\_\_\_\_

I have read and initialed all of the above and I certify that I understand and agree to its content.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Patient or Responsible Party Signature

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Consent to Discuss Treatment**

Patient Name: Date of Birth:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First MI Last

Check one:

I authorize Healthy Life Solutions to discuss my treatment with the following individuals listed below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

I do not authorize discussion of my treatment with any individuals.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date