***Patient Consent for Treatment--Resilience Mental Health Services LLC***

My signature below indicates that in accordance with HIPAA, I am aware that Resilience Mental Health Services LLC Privacy Policy, Patient Rights and Responsibilities, and Financial Policies are available to me upon my request.

My signature indicates that I assign any payment from my insurance carriers to be paid directly to Resilience Mental Health Services LLC. I understand that billing any secondary insurance is my responsibility. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that my health care information may be disclosed for information to the insurance companies listed above and their agents for the purpose of obtaining payment for services and determining insurance benefits.

I voluntarily request consent and authorize my attending provider, their associates, assistants, or other practitioners under their orders to attend to myself, my minor child, or my ward at Resilience Mental Health Services LLC. I further authorize my providers to deliver medical treatment or HIV testing, including but not limited to diagnostic procedures, x-rays, and administration of medications, as is deemed necessary and advisable within the boundaries of the clinic’s provided services.

I hereby give consent to Resilience Mental Health Services LLC to obtain information regarding medication prescriptions and past medical history.

I hereby give consent to Resilience Mental Health Services LLC to use or disclose my Protected Health Information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I understand that Resilience Mental Health Services LLC has the right to change their privacy practice and I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my Protected Health Information is used. However, I also understand that Resilience Mental Health Services LLC is not required to agree to that request.

If the clinic agrees to the requested restriction they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing except for information already used or disclosed.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_