House Psychiatric Clinic – Consents

Patient Name: _____

Consultation & Assessment: I understand that my first session with HPC is for consultation only. This consultation is for an assessment of my mental health. It may take more than one session to complete this assessment. I understand that treatment is not initiated until HPC agrees to do so.

___ **I consent**

Limits on confidentiality: Under State and/or Federal Law, HPC is required to disclose confidential information if any of the following exists: 1) You are a danger to yourself or others; 2) We suspect the abuse of a minor, a senior, or a dependent person; 3) You request a release of your records; 4) A judge subpoenas your records; and/or 5) If you are using insurance to pay for treatment, your insurance company has the right to review your records.

___ **I consent**

If I am using insurance, I authorize my insurance benefits to be paid directly to HPC or any clinician at HPC. I understand that if I do not present my insurance card at my first visit, I will be required to pay the full visit cost.

___ **I consent** ___ **I am not using insurance**

I understand that if I have a deductible, a minimum of $30.00 will be collected at the time of service. Any potential overpayments will either be applied to my account or refunded to me.

___ **I consent**

I understand that my payment, copay, deductible, no-show payment and/or outstanding balance is due at the time of service, even if I have secondary insurance. Medi-Cal patients that have a "Share of Cost" or "Spend Down" will be required to pay the amount due at the time of service. HPC requires a credit/debit card to be on file and account balances will be charged to the credit card on file. Account balances over 90 days old will be sent to collections.

___ **I consent**

I understand that my account/credit card will be billed for all appointments canceled without sufficient notice. Medication appointments require 24-hour notice. Therapy appointments require 48-hour notice. Missed appointments and late cancels are charged the full rate of the appointment.

___ **I consent**

For our patients using Medi-Cal insurance, we will not bill for no-shows or appointments canceled without sufficient notice. However, we reserve the right to terminate treatment for a no-show or an appointment canceled with less than sufficient notice.

___ **I understand**

At HPC, we work to create a safe environment for everyone. For this reason, we have a Zero Tolerance Policy for disruptive behavior in the office. We will terminate treatment for disruptive, offensive, or unsafe behavior.

___ **I understand**

I acknowledge I have been given House Psychiatric's Notice of Policies and Practices.

___ **I consent**

By signing your name, you are agreeing to the above statements.

Please sign here: _____ **Date signed:** _____