Consent to Treat

The following information is to acquaint you with the policies and procedures of *Mountain View Behavioral Health Office.*
Please read and sign this form.

Confidentiality-In 2003 HIPAA, or the Health Insurance Portability and Accountability Act went into effect. This refers to how and when patient information may be used and disclosed, to patient access and control over PHI (Protected Health Information) and to administrative procedures regarding PHI. You will be given a copy of HIPAA Notice of Privacy Practices for review and to maintain for your files. This will explain in detail how your provider mayor may not disclose the information that is contained in your file/chart. Please read it carefully.

Appointments: If you are unable to keep your appointment, you will need to cancel a minimum of 24 hours in advance.

Your provider has reserved this time for you. You will be charged for your visit if a no show occurs or this office has not been given a 24 hour cancellation notification. No show/late cancel fee is $120.00 for a therapist and $85.00 for MD follow up appointments.

Emergencies: If you have an emergency situation, Mountain View Behavioral Health, Inc. has an "On Call" provider available 24 hours a day. Your Behavioral Health Care provider will instruct you· as to what to do or handle the situation depending on the emergency.

Payment: All co-pays and cash payments are due and payable on the day of your visit to Mountain View Behavioral Health either by cash or check. There will be a $25.00 charge for all returned checks.

Your Signature Below Indicates the Following:

* I have read and I understand the above information regarding procedures.
* I authorize treatment of myself or the dependent indicated as the patient.
* I understand that if my Behavioral Health Care provider requests authorization for additional sessions from my Behavioral Health Care Company this falls under HIPAA Treatment, Payment, and Healthcare Operations or (TPO).
* I will authorize in writing, through a signed Authorization to Release, communication between your attending Behavioral Health Care provider and my medical providers for Coordination of Care. I will also indicate if this information can be discussed verbally, via telephone or by facsimile.

_____ _____

Patient Name (Please Print) Date

_____ _____

Patient/Responsible Party Signature Provider Name