NORTH POINTE PSYCHIATRY, P.A.

Patient Registration and Consent for Treatment

This consent applies to a verity of patient situations. Due to practical limitations, alterations are not accepted. If you have any questions regarding this consent form, office management will be happy to assist you.

I. CONSENT FOR TREATMENT:

I am presenting myself to **NORTH POINTE PSYCHIATRY, P.A.** for evaluation, diagnosis and/or treatment of my medical condition. I give consent and authorize my physician(s) or his designees to perform and/or perform all exams, test, procedure and any other deemed necessary or advisable for the evaluation, diagnosis and treatment of my medical condition. This consent is valid for each visit I make to **NORTH POINTE PSYCHIATRY, P.A.,** unless and until revoked by me in writing. I acknowledge that **NORTH POINTE PSYCHIATRY, P.A.** is committed to protecting the confidentiality of my medical record information in accordance with applicable laws and regulations. However, in order to provide treatment to me and to conduct billing and other health care operation activities, NORTH **POINTE PSYCHIATRY, P.A.** requires permission to disclose my medical records to certain individuals and entities. Therefore, I give Consent and authorize **NORTH POINTE PSYCHIATRY, P.A.** to disclose any of all of my medical record information, including but not limited to treatment information, insurance and other financial information and information about communicable diseases such as human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome(AIDS), alcohol and substance abuse, mental health diagnosis and treatment, and laboratory test results(ñMedical Recordsò), to the following individuals and entities:

- Physicians and other health care personal who are involved in providing or managing my health care. Disclosure to these individuals occurs through the sharing of paper medical records and through access to electronic systems
- my health insurance plan, Medicaid, Medicare, or any other person or entity that may be
- responsible for paying or processing payment for my medical treatment;
- Employees, agents, representatives, volunteers or contractors of **NORTH POINTE PSYCHIATRY, P.A.** for the purpose of conducting health care activities including but not limited to administration, billing, compliance, quality assurance, risk management, credentialing and any other appropriate health care facility activities or operation:
- Any person or entity to which I give written authorization to receive my Medical Records on a form provided by **NORTH POINTE PSYCHIATRY, P.A.** or such other forms acceptable to **NORTH POINTE PSYCHIATRY, P.A.**
- Any other person or entity that is required by law to have access to my Medical Records. I understand that the disclosure of my Medical Records may be necessary before my insurer will pay for the cost of my medical treatment. I agree not to hold NORTH **POINTE PSYCHIATRY, P.A.** its agents or employees liable for any damages as a result of disclosing my Medical Records in accordance with this consent.

II. ASSIGNMENT OF BENEFITS/CAUSES OF ACTION: In consideration of services or to be rendered to the patient, I assign my transfer to **NORTH POINTE PSYCHIATRY, P.A.** up to the amount of my total financial obligation to **NORTH POINTE PSYCHIATRY, P.A.** all right, title and interest in benefits payable out of any third party action, or out of recovery under the uninsured motorist provisions or out of the medical payment provisions of any automobile insurance policy (ies), or out of any other insurance proceeds that I am entitled to recover. I further authorize **NORTH POINTE PSYCHIATRY, P.A.** to pursue on my behalf any claim I may be entitled to pursue before the Crimes Victims Compensation Division of the Texas Industrial Accident Board in the event my treatment is necessitated by injuries received as the result of a violent crime, but in no event shall this be construed to be an obligation of **NORTH POINTE PSYCHIATRY, P.A.** I understand that this agreement in no way restricts me or my dependentsô rights to pursue any such claim before the Crimes Compensation Division of the Texas Industrial Accident Board.

III. FINANCIAL RESPONSIBILITY:

In consideration of services rendered or to be rendered to the patient, I accept financial responsibility and agree to pay for any and all charges and expenses incurred or to be incurred. I further understand that payment is due upon request. Unless **North Pointe Psychiatry, P.A.** has a contract with my insurance carrier that states otherwise**, I am responsible for my remaining balance after reasonable collection efforts have been pursued with my insurance company.** If my account becomes delinquent and it is necessary for my account to be referred to attorneys or collection agencies, I will pay all charges that are my obligation, reasonable attorneyôs fees and other collection expenses. I have received a copy of the practice police.

IV. FEDERAL AND STATE PROGRAMS:

If I am eligible for health care benefits under any federal of state program, including but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs, including Title XVIII and XIX of the Social Security Act, is correct. I authorize any holder of medical or other information about me to the Social Security Administration or intermediaries or carrier any information needed for any federal or state program related claims, I request that payment of authorized benefits be made to **North Pointe Psychiatry, P.A.** on my behalf. I understand that I am responsible for all applicable health insurance deductible and co-insurance amounts under these programs.

V.ACCIDENTAL EXPOSURE OF HEALTH CARE WORKERS:

I understand that Texas Law provides, and I give consent, that I may be tested for possible exposure to certain communicable disease, including but not limited to the human immunodeficiency virus (HIV), the virus associated with AIDS, hepatitis B and C, and syphilis, Such testing will be conducted pursuant to applicable laws and can include but in not limited to the following situation, 1) if a health care worker is exposed to my blood or other bodily fluid.

VI. PRACTICE POLICIES:

By signing the Patient Registration and Consent for Treatment form (Consent), I acknowledge that I have been offered a copy of the practice policies of **North Pointe Psychiatry, P.A.**

VII. EFFECT OF CONSENT:

By signings the Patient Registration and Consent for Treatment form (Consent), I acknowledge that I have read and understand the information contained in this Consent. I accept the terms of this Consent, either on behalf of myself as the patient, or on behalf of the patient as an authorized legal representative of the patient.

This Consent supersedes all prior consents or other authorization forms signed by me pertaining to issues discussed herein. I acknowledge that signing the Consent is a condition of treatment by **North Pointe Psychiatry, P.A** and alteration of any/or refusal to sing this form will result in denial of treatment, I understand that I may revoke this Consent at any time, except to the extent that **North Pointe Psychiatry, P.A**. has initiated actions based on the Form. Any revocation of the Consent may result in termination of patient care in accordance with the state law.

If signing as the legal representative, I represent to **North Pointe Psychiatry, P.A.** that I am the legal representative of the patient. Should my legal authority terminate, I agree to provide written notification to **North Pointe Psychiatry, P.A.**

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Patient/Guardian Printed Name	Patient/ Guardian Signature	Date