WELLCORE PSYCHIATRY OF MARYLAND, LLC

Consent to Bill, Treat, Release of Information and Financial Responsibility Guarantee

1. **CONSENT TO MEDICAL CARE:** By my signature or electronic signature below, I voluntarily consent that I will participate in a mental health evaluation and treatment by professional staff from WELLCORE PSYCHIATRY OF MARYLAND, LLC. I understand that the practice of psychiatry is not an exact science, and that there are risks and benefits associated with receiving psychiatric treatment. I acknowledge and agree that no guarantees are made to me concerning the results and outcomes of the mental health evaluation and treatment rendered by the professional staff from WELLCORE PSYCHIATRY OF MARYLAND, LLC.

2. **RELEASE OF MEDICAL RECORD INFORMATION:** I hereby authorize WELLCORE PSYCHIATRY OF MARYLAND, LLC, to disclose all or any part or the contents of the medical record of the patient named on this Registration Form to such insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered to the registered patient(s) consistent with Federal HIPAA regulations. This authorization is given with full knowledge and understanding that such disclosure may contain information which may result in a valid denial of insurance benefits, or which otherwise may not serve my interests. I further authorize WELLCORE PSYCHIATRY OF MARYLAND, LLC to share information to any of my current medical and/or psychological and/or diagnostic treatment providers.

3. **PRIVACY POLICY ACKNOWLEDGMENT:** I acknowledge that I have received a copy of the Notice of Privacy Practices and Patient's Rights for WELLCORE PSYCHIATRY OF MARYLAND, LLC. I understand that this consent includes my agreement that WELLCORE PSYCHIATRY OF MARYLAND, LLC, can use private health information for my treatment and the billing of my treatment as defined in the Notice of Privacy Practices and Patient's Rights.

4. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby request and authorize that any and all insurance benefits due and payable for medical and psychiatric services and rendered to me to be paid directly to WELLCORE PSYCHIATRY OF MARYLAND, LLC.

5. **FINANCIAL AGREEMENT and GUARANTEE:** I accept full and complete financial responsibility for all charges due to WELLCORE PSYCHIATRY OF MARYLAND, LLC, for medical and psychiatric

services rendered to me. I agree to pay any and all charges that are not covered by my insurance including insurance co-payments, deductibles, and co-insurance that may be required under the terms of my medical insurance policies, including any medical care that is considered a "non-covered" service under the terms of my medical insurance plan. This is the policy of

1. my insurance company, which WELLCORE PSYCHIATRY OF MARYLAND, LLC, is required to comply with.

6. **PAYMENT ARE DUE WHEN SERVICES ARE RENDERED:** I accept that all estimated charges must be paid at the time of each visit, before services are rendered.

7. **CHARGES FOR COLLECTION SERVICES:** I further acknowledge, understand and agree, that in the event that I fail to make any payments, in accordance with a payment plan or in the event of default of my financial obligation to pay for services rendered, WELLCORE PSYCHIATRY OF MARYLAND, LLC, may terminate the "doctor-patient" relationship with me and provide me with information to seek care with another provider. Furthermore, in the event of my default of my financial obligation, should my account be turned over to an external collection agency for non-payment, I agree to pay any associated collection costs.

8. **MISSED OR CANCELED OFFICE VISITS:** Office visits are by appointment only. Patients are asked to arrive 15 minutes before the scheduled appointment time in order to complete the check-in process. Patients arriving more than 20 minutes late may be required to reschedule their appointment to the next available opening consistent with the type of appointment requested.

9. **APPOINTMENT NO-SHOW CHARGES:** As a courtesy to both your provider and patients, we ask that you cancel any scheduled appointment at least 24 hours in advance so that others may utilize this time. Failure to attend an appointment without cancellation at least 24 hours in advance is considered a **NO SHOW. NO SHOWS** are charged to the patient at $75.00 per missed visit.

10. **PRESENT A VALID INSURANCE CARD AND IDENTIFICATION CARD AT EACH VISIT:** If you request that we bill your insurance for your care, in addition to paying any applicable insurance co-payments, deductibles, and co-insurance, you must present a valid insurance card AND valid identification card at each visit. I understand that if I am unable to present a valid insurance card, I may be required to make a full payment as a self-pay

patient for that visit.

11. **AUTHORIZATION OF TREATMENT FOR CHILDREN UNDER 18:** Children Under the age of 18 cannot legally consent to their own evaluation and treatment. Evaluation and treatment can only be approved by a parent or legal guardian. If you cannot attend the child's appointment and must send them alone, or with another supervising individual, please be aware that they have no legal authority to provide "consent to treatment" for your child. You must send a SIGNED LETTER OF AUTHORIZATION WITH THEM, or give us written pre-authorization naming the person(s)

WELLCORE PSYCHIATRY OF MARYLAND, LLC

Consent to Bill, Treat, Release of Information and Financial Responsibility Guarantee

you approve in advance to consent to evaluation and treatment on your behalf. If you wish to do this, please request a PRE-AUTHORIZATION FORM from our front desk staff.

CORRECT INFORMATION: The undersigned certifies that he/she has provided correct information about the patient during registration and understands that any false statements or concealment of material fact may be prosecuted under applicable federal and state laws. The undersigned further certifies that he/she has read, fully understands, and accepts the above information, terms and conditions, and is the patient's parent or legal guardian, or is duly authorized to execute the above and to accept its terms.

PRINT Patient Name Date of Birth

Signature of Patient, Parent/Legal Guardian or Legally Authorized Representative Date

Print Name of Signature (if other than patient)