
# CONSENT FORM

Address: **1100 Northwest Loop 410 Suite 700**
**Castle Hills, TX 78213 United States**
Phone: **+1(210)-441-6024**
Email: **olanike@liveoakpsychiatry.com**

**Name** **Date of Birth**

**First** **Last** **MM** **DD** **YYYY**

**• Please initial indicating you have read and understood all the terms and conditions for the items listed below**

## General Consent:

I give permission to **LiveOak Psychiatric and Family Practice** (hereafter called **LPFP),** i its designated staff, and other medical and social service personnel providing services, case management and counseling under its sponsorship to provide services as indicated by license and/or title including physical and/or mental health assessments or examinations, conduct laboratory or other tests, give injections, medications and other treatment as appropriate and render any other physical or mental health services to the patient identified on this form.

**Release of medical/mental health information:**

I give permission for medical and mental health information obtained by L**PFP** to be released to other health care providers as is necessary for referral purposes only. I furthermore understand that **LPFP** uses electronic records and these records are shared within staff providing services.

Health Insurance Portability and Accountability Act (HIPAA)
**https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html**

By initialing below, I received, read, and understand my rights under HIPAA.

**Payment Policy:**

It is my responsibility to confirm that the clinician/physician is a covered provider under my insurance plan. I hereby authorize the assignment of benefits (payments) directly to **LPFP** for all my insurance claims related to services received. I understand that I am financially responsible for services provided which are to be paid on the day services are rendered. This includes co-payments/deductibles with any managed care contract and non-covered services.

## The statement below is for patients who have insurance:

I authorize the release of any medical or mental health information necessary to process reimbursement for treatment services and request payment of Medicare/Medicaid (or any other third party reimbursement, public or private, for which I may be eligible).
**FOR MEDICARE/MEDICAID**: I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. Photocopy shall be valid as an original*. I request that payment of authorized Medicare and/or Medicaid benefits be made on my behalf to **LPFP** for any services furnished to me by the providers of this group. I authorize any holder ofmedical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature authorizes requests for payment as well as release of any medicalinformation necessary for CMS or the Medicaid payer to pay the claim. I also acknowledge that **LPFP** agrees to accept the charge determination of the Medicare carrier as the full charge and I agree to be responsible only for the deductions, coinsurance, or non-covered services. Coinsurance and deductible amounts are based on the charge determination of the Medicare carrier. The clinic agrees to accept Medicaid Paymentisn accordance with Medicaid regulations as payment in full.


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**MEDIGAP RELEASE:** For Medicare Patients with supplemental Medigap insurance a separate signature is needed. I request Medigap benefits be made on my behalf for services rendered. I authorize release to my Medigap carrier any information needed to determine benefits.

**Signature:**

**Date: (mm/dd/yyyy)**

**• Records and Confidentiality**
In the case of medical services, behavioral health services, counseling and case management, all communications become part of the clinical record. The clinical record may be viewed by the providers in the medical clinic and behavioral health department for reasons including; consultation or transfer of clients due to vacation, illness, termination or death. This is kept confidential with the following exceptions:

1. You provide us with a written release to share our information with someone else.
2. Reporting abuse or neglect as required by law.
3. We determine that you are a danger to yourself or others.
4. We are ordered by a court to disclose information.

**Signature:**

By typing your signature, you certify that this form was fully explained to you and that any questions you have about services have been answered to your satisfaction.
**Once you have completed the form, please email the form to nkatibi@liveoakpsychiatric.com with your first and last name in the subject box*