Consents and Authorizations

Treatment and Policy Consents

1. I have the legal right to authorize and I hereby consent for services for myself or my dependent at PRA which may include evaluation, psychotherapy, medication management, group therapy or psychological testing (if indicated). For minors 17 & under, consent of all guardians is required.
2. I authorize communication within the PRA treatment team which includes your psychiatrist and therapist, covering clinicians and office personnel in order to provide comprehensive treatment services.
3. When paging a PRA MD or therapist, **please turn off any privacy manager features** you may have on your phone so they may return your call promptly. I understand that my failure to turn off privacy manager features or not leaving a clear phone number for my MD/therapist may result in a delay or inability for my clinician to respond. In cases of an emergency, call 911 or go to your closest emergency room for assistance. In addition, MD/therapist voicemails will guide you on how to page your clinician. Please follow the guidelines and instructions on your clinicians' voicemail to page them for urgent needs.
4. I understand that appointments not canceled at least 24 hours in advance will be billed to the patient at the session rate and **cannot be billed** to, nor reimbursed by insurance (even if our office has a contract with your insurance company).
5. I understand that follow up treatment is required to maintain ongoing quality care. PRA MD's require follow up every three months. Failure to follow up on the recommended basis may result in prescription refills being denied. Lack of follow up for over 6 months with any PRA clinician will automatically result in your case being made inactive with our practice. You may require a new evaluation if you are requesting to be seen again should the clinician be willing to reopen your case.
6. I understand that clinicians at PRA may refer me or my family members to clinicians or services outside of the practice should they feel they cannot provide the necessary treatment needed to effectively and ethically treat you or your family members' clinical issues. In addition, reasons for termination from PRA may include but are not limited to threatening or abusive behavior; fraudulent use of controlled substances, refusal to follow treatment recommendations, frequent missed appointments or failure to follow up with appointments on a regular basis.
7. PRA does NOT use email as a method to communicate clinical, urgent, appointments or other treatment related issues especially if time sensitive. I understand that I must contact PRA by phone for all patient clinical, urgent or administrative concerns. I understand that PRA's website's Contact Us page is for general information only and is not meant as a vehicle to communicate treatment issues to PRA clinicians.
8. PRA utilizes a web based company RXNT to send prescriptions for your convenience. I authorize PRA to send prescriptions electronically and understand that PRA follows all Federal Privacy Security Laws to protect your healthcare records. I also consent for PRA MD's to review the claims medication history on my RXNT account. I understand I may revoke this consent at anytime by giving written notice to my physician.
9. I have received a copy of PRA's Notice of Privacy Practices and understand and agree to my responsibilities as a patient receiving services from the named PRA provider listed on the Client Information Form.
10. Medical record requests must be made in writing with the appropriate release signed indicating where the medical records need to be released to. To start this process, please contact our Medical Records coordinator at 847-240-2211 x223 to review the necessary paperwork, releases and **fees** associated with medical records requests. Please be aware fees do apply.

For more detailed Office Policies, please see our website at www.prapsych.com

I have read, understood, and agree to the consents and authorizations above regarding my responsibilities as a patient receiving services from clinicians at PRA. For patients 17 & under consent for treatment signatures for both parents are required below.

Signature of Patient (age 12 and older)	Date	Signature of Responsible Party/Guardian #1 (if different than patient)	Date
Print Patient's Name		Signature of Guardian/Parent #2	Date
PRA MD/THERAPIST you are seeing today.		Witness	Date

3/2020

White Copy: Therapist/MD file **Yellow Copy: Billing** **Pink Copy: Patient Copy**

Financial Consents/Authorizations

A. I have completed the demographic and insurance information on the Client Information Form to the best of my knowledge and authorize PRA to release any medical information (including types of services, dates/times of services, diagnosis along with treatment plans, progress of treatment, case notes and summaries, if necessary) to process my insurance claim(s).

B. As a courtesy to our patients, we attempt to contact your insurance company to obtain benefit information for your care here at PRA. **Benefit results given to patients by our office is not a guarantee of payment by your insurer. I understand that benefits obtained by PRA office staff are estimates based on information given to us by your insurance company.**

C. I hereby assign all medical, including Major Medical benefits to which I am entitled, private insurance and any other insurance programs to PRA. A photocopy of this assignment is to be considered as valid as original. This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges, whether or not paid by said insurance and that I will be responsible for any amounts uncollected by PRA. **In addition, I understand that failure to keep current with payments may cause an interruption in treatment services until a payment plan or balance due is paid.** In addition, I agree to inform PRA of any contact or insurance information changes promptly. Failure to do so may result in claims not being filed timely with your new insurance company resulting in the responsible party being liable for any amounts unpaid by the insurance company.

D. You will be provided with all the required documentation to file claims with your insurance company. If we have a contract with your insurance company, our office will bill your insurance company for the provider portion; however; any deductibles, co-pays and/or applicable fees are due at the time of your office visit. A **fee** will be charged if due copay, coinsurance or deductibles are not paid at the time of service. We accept Cash, Checks, Money Orders and Credit Cards (Visa, MasterCard, Discover and American Express). We do not have the ability to make change for cash. The office charges a $35 return check fee for any checks returned to our office by our bank. You may be requested to provide a credit card number to be kept on file for forgotten payments, missed appointments, co-pays and patient balances. We will inform you in the event that we have processed a charge for payment for services that are outstanding past 60 days. Credit Card information is stored in a secure and confidential manner. You can pay online from our website www.prapsych.com and hit the "PAY NOW" button

E. For patients under 18 years of age and young adults: If you are a parent and are unable to accompany your child who is a patient to the appointment, please send them with a check or we can put a credit card number on file. If there is a divorce agreement between parents on financial responsibility the parent that accompanies the patient is responsible for making the co-payment at the time of service. I understand that PRA is not responsible for upholding financial agreements made between parents in divorce situations.

F. If fees for services are not paid in a timely manner and we don't have a credit card on file authorizing us to charge for patient balances, I understand that failure to pay due balances, not responding to statements or make agreed upon payments on my or family members account, may result in discontinuation of treatment services resulting in referrals outside PRA.

G. PRA clinicians are contracted and receive compensation for concurrently rendering services to a patient and divide the fee for such service. The fees received are made in proportion to the actual services personally performed and responsibility assumed by each clinician. I fully acknowledge the division of fees.

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