BEACON BEHAVIOR PEDIATRICS

CLIENT CONSENT FORM

Welcome to Beacon Behavioral Pediatrics We look forward to addressing your pediatric mental health needs. We encourage your questions and participation in all aspects of your health care.

THE FOLLOWING DOCUMENT IS COMPRISED OF THREE SECTIONS:
1) OFFICE POLICIES AND FINANCIAL AGREEMENT
2) HIPAA PRIVACY POLICY
3) CONSENT TO TREATMENT

**PLEASE MAKE SURE TO READ THROUGH THIS DOCUMENT IN ITS ENTIRETY, INITIAL EACH BOX APPROPRIATELY, AND INSERT YOUR SIGNATURE AT THE BOTTOM.

I. OFFICE POLICIES & FINANCIAL AGREEMENT

The patient is a minor child who will receive professional mental health services at Beacon Behavioral Pediatrics

☐ **Yes** ☐ **No**

Name of Financially Responsible Party (FRP): _____

Relationship to Patient: _____

Fee-For-Service Practice

Beacon behavioral pediatrics is a "fee-for-service" private practice and is not on any health insurance panels. The policy of Beacon behavioral pediatrics is that the financial fees for patient appointments shall be paid in full by the patient or the Financially- Responsible Party (FRP) on the day of the patient's scheduled appointments. For your convenience we accept cash, check (payable to Beacon behavioral pediatrics VISA, Mastercard, and most major credit cards. For telephone and virtual appointments, we require to have a valid credit card on file for the patient at the time the appointment is scheduled.

I Understand and Agree: _____

Out-of-network

Beacon behavioral pediatrics does not have a formal business relationship with any health insurance company and cannot submit insurance claims on behalf of its clients. WE will provide you with an invoice that you can submit to your insurance company for out-of-network reimbursement. It is your responsibility to verify your out-of-network coverage, benefits, limits, and exclusions for mental health services with your insurance company prior to your first office visit.

I Understand and Agree: _____

Appointment Late Cancellations and "No Shows"

It is our policy at Beacon behavioral Pediatrics to reserve a patient's appointment time especially for that person in the Doctors calendar. If a patient must cancel or reschedule an appointment, they must contact our office via our main office number or email, within a minimum of 36 hours prior to their appointment to inform the practice. If a patient notifies our office about their cancellation or rescheduling with fewer than 36 hours' notice, they will be responsible to pay 25% of the appointment fee. Patients who do not appear for their appointments without any notice to our main office telephone or email prior to their appointment will be responsible to pay 100% of their appointment fee.

I Understand and Agree: _____

Other Account Fees

Any unpaid account balance that is past due thirty (30) days will be subject to a $50 late fee and will accumulate in $50 increments each subsequent 30 days. If a personal check is returned by our bank due to insufficient funds, the patient will be contacted and invoice the original appointment fee plus a $25 returned check fee, and any applicable late fees

I Understand and Agree: _____

Dismissal Policy

Dismissal Process: There are many reasons that a patient may be dismissed from our practice. A few reasons are as follows: Failure to keep scheduled appointments, Failure to meet financial obligations, being verbally or physically abusive to staff. A letter (may or may not be certified) will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within 30 days of the date of the letter, our provider will be available for advice. After the 30 days, you will no longer be seen at our practice. A copy of your medical records may be forwarded to your new doctor after a formal request is made and applicable fees (if any) are paid

I Understand and Agree: _____

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II. HIPPA NOTICE OF PRIVACY PRACTICES

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We follow HIPAA guidelines for your protection and you have the right to your medical information. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with Dr. Adekugbe.

I Agree and Understand: _____

Consent to Discuss Private Health Information (Applicable Only to Patients 18 years of age and older.)

Beacon behavior pediatrics may discuss my Patient Treatment Progress --which is my Private Health Information (PHI) with my FRP upon their request. I understand that I will still need to complete a separate Release of Information form, on a caseby-case basis, in order for the doctor to share my medical records with my FRP or another party.

I Disagree ☐ **I Agree** ☐

III. INFORMED CONSENT FOR MEDICAL AND PSYCHOTHERAPY TREATMENT

I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed by discussing the potential benefits, risks and hazards involved

The undersigned patient or responsible party (parent, legal guardian) consents to, and authorizes services, by beacon behavioral pediatrics. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures. The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

I Understand and Agree: _____

By signing and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I understand the above-stated office policies and the financial agreement with Beacon behavioral Pediatrics and will comply with them in all respects. I acknowledge that I have received the HIPPA policy. Lastly, I understand all of the above and give my oral and written consent to the evaluation and treatment to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Name of Patient: _____

Name of Guardian (If Applicable): _____

Date: _____

Signature of Parent/Guardian (If Applicable) _____