Consent Form

PLEASE READ THIS ENTIRE AUTHORIZATION BEFORE SIGNING

GENERAL CONTACT INFORMATION

Normal business hours are 10 am - 5 pm, Monday thru Friday. You may contact our office during normal business hours at 832-639-2015. For urgent matters that occur outside of normal business hours, call the above number and leave a voicemail and a provider will return the call as soon as possible. Emergencies must dial 911 immediately or go to the nearest emergency room.

GENERAL CONSENT FOR MEDICAL SERVICES

I request and authorize Flourish Mental Health, the ("Practice"), its agents and employees and my physicians, their associates and assistants ("Providers") who may attend to me during the outpatient visit to provide and perform such medical care, tests, procedures, and other services and supplies as are considered advisable by my provider for my health and well-being. A provider will not be on-site 24 hours/day 7 days per week. A copy of this authorization shall be considered as effective and as valid as the original.

GENERAL RATES AND FEES

The Practice is an "out of network" provider which means that insurance will NOT be billed for services provided. Patients are required to pay the full amount in advance. Documentation will be provided to the patient which can be submitted to the insurer for partial reimbursement.

Dr Bryant - $200 per half hour
Forensic (court) evaluations/documentation: $6,000 retainer, $600 per hour.
George Attobrah, Nurse practitioner - $100 per half hour
Forensic (court) evaluations/documentation: $3,000 retainer, $300 per hour.
Stephanie Bloodworth, Therapist - $60 per half hour
Forensic (court) evaluations/documentation: $2,000 retainer, $200 per hour.

Medication Management - **Initial visit is typically one hour and follow up visits 30 minutes. This includes time that the patient misses due to late arrival and any additional time that is required beyond the scheduled appointment time. Phone calls/emails with provider will also be billed at above rate if over 10 minutes.**
Therapy - **Visits are typically one hour. Additional time can be provided as needed at 30 minute increments. This includes time that the patient misses due to late arrival and any additional time that is required beyond the scheduled appointment time. Phone calls/email with provider will also be billed at above rate if over 10 minutes.**

RESCHEDULED, CANCELLED AND MISSED APPOINTMENTS

When you schedule an appointment with our office, that time is specifically for you. By making an appointment, you accept responsibility to pay the full fee for the professional time that is reserved for you. **Our office has a policy of charging patients for the full cost of any appointment the patent fails to attend UNLESS THE APPOINTMENT IS CANCELLED AT LEAST 48 HOURS IN ADVANCE.** To avoid charges, cancellations must be made by communicating to the office the patient's desire to cancel the appointment at least 48 hours in advance of the scheduled appointment time. A credit card will be kept on file to pay for these charges.

INSURANCE

MEDICARE PATIENTS ONLY: The Practice is an "out of network" provider of services and therefore cannot bill Medicare for its services. Patients with Medicare will be required to sign an additional contract stating that he/she understands that Medicare cannot be billed for reimbursement. All charges and fees are the responsibility of the patient.

COMMERCIAL INSURANCE: The Practice is an "out of network" provider. This means that the patient is responsible for all charges and fees which are due at the beginning of each appointment. Documentation will be provided which can be submitted to you insurer for partial reimbursement. You can contact your insurer in advance to discuss how much reimbursement they will provide.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and our Providers. In most situations we can only release information about your treatment to others if you sign a form that meets certain legal requirements imposed by HIPPA. There are some situations where we are legally obligated to take actions which we believe are necessary to attempt to protect you or others from harm and we may have to reveal some information about a client's treatment.

- If a client threatens to harm himself/herself we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

- Child Abuse: If we have reason to believe that a child has been injured because of brutality, abuse, neglect, or has been sexually abused the law requires that we report this to Child Protective Services. Once a report is filed, we may be required to provide additional information.

- Adult and Domestic Abuse: If we have reason to suspect that an adult has suffered abuse, neglect, or exploitation the law requires that we report to the Department of Human Services. Once a report is filed, we may be required to provide additional information.

- Serious threat to health or safety: If a client communicates a threat of bodily harm against a clearly identified victim and we believe that the client has the ability and is likely to carry out the threat, we are required to take steps to protect the victim, including notifying the potential victim, notifying the police, or seeking hospitalization for the client.

If such a situation arises, we will limit our disclosure to what is necessary.

FINANCIAL CONSENT/ASSIGNMENT OF BENEFIT AND RELEASE OF INFORMATION

I hereby assign payment to (1) the Practice; (2) health care providers who are not employees of the Practice, but who have a contract with the Practice to provide services, such as Contract Physicians, Anesthesiologists, Radiologists, Pathologists, and Mental Health providers; and (3) health care providers who have no employment or other contractual agreement with the Practice, such as paramedics, and authorize them to release a copy of my medical records and release and any other information necessary for them to obtain payment from my insurance, Medicare, Medicaid, worker's compensation carriers, and Social Security Administrators with whom I have coverage or benefits that are, or may become, payable to me, including settlements or judgments from the incident for which I am receiving treatment. I acknowledge that the providers in categories two (2) and three (3) above are not employees or agents of the Practice and I understand that the Practice is not liable for the acts of the providers in categories two (2) and three (3). I agree to pay, when billed or requested by the Practice, any amount charged for Practice services not covered by the above payers.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

By signing this form you agree to abide by all the terms contained herein. You also agree to pay the Practice and the health care providers listed above all the charges promptly when due. Payment is expected at the time of service. If your account is not paid timely, the Practice reserves the right to discontinue treatment until payment arrangements have been made. If your Practice account, or account with the health care providers listed above is forwarded to a collection agency or attorney: (1) whether or not legal proceedings are instituted, a collection agency fee not to exceed 20% of the account balance or One Thousand Dollars ($1,000), will be added to your account balance forwarded, and (2) you will be responsible for any court costs, reasonable attorney fees, and interest as allowed by Texas statute, incurred in the collection of your account.

The undersigned agrees that he/she has read, understands, and agrees to all parts of this consent form and any questions have been answered before signing.

____________________	____________________
Printed Name	Relationship to Patient
____________________	____________________
Signature	Date

Credit Card Authorization

Patient's name: ______________________________

Name (as it appears on credit card): ______________________________

Billing Address ______________________________
____

Credit card type: ____ Visa ____ MasterCard ____ Discover ____ Amex

Credit card number: ______________________________

Expiration date: ________________ Security code: ________________

I understand that full payment is required at the time of service by either cash, check, or credit card. Full payment is also required for missed appointments and cancellations with less than 48 hours prior notice.

I also understand that the financial responsibility for services provided is mine, and that I must file for any insurance reimbursement to which I may be entitled because Flourish Mental Health, PLLC will not file insurance claims on my behalf.

I understand that the credit card listed above will be charged for services rendered and for the missed and cancelled appointments with less than a 48-hour notice. If the credit card charge is denied, I will be billed separately for the appointments. Flourish Mental Health will not schedule any further appointments until I pay all outstanding balances.

I waive any and all rights to cause a charge-back (i.e. a disputed, reversed, or contested charge) against this purchase for any reason.

I agree to call and notify the receptionist in advance of my next scheduled appointment if my address, phone number, or responsible party has changed.

I hereby authorize Flourish Mental Health, PLLC to charge my credit card for services rendered to me or the patient whose name appears above (and for appointments missed or cancelled with less than a 48 hour notice).

By signing below I am authorizing Flourish Mental Health, PLLC to charge my credit card for the professional services as described above. I certify that I am the owner of the credit card listed on this form and can authorize charges to this card.

______________________________ ____________________
Signature Date