CONSENT TO TREATMENT

Please Complete This Page

Name of Client: _____

- I have read, understand, and been given a copy of the Client information on Office Practice and Policies
- I have signed a copy of the Notice of Privacy Practices (HIPAA-related)
- I give my consent to treatment by Dr. Beverly Davis
- If I want to use insurance, I authorize Dr. Beverly Davis to file for my insurance and to accept assignment of insurance payment for her services unless otherwise specified above
- I understand that if I use insurance, Dr. Beverly Davis may be required to communicate with representatives of my insurance carrier.
- If my insurance company or managed care company does not cover services I realize that I am responsible for all fees for services provided
- If I have any concerns or complaints about my treatment, I understand I should talk with Dr. Beverly Davis regarding them.

Client Signature _____ Date _____

I further consent to the evaluation and/or treatment of my minor child in my legal custody or guardianship.

Signature of Guardian (if applicable)

_____ Date _____

Signature of Dr. Beverly Davis

_____ Date _____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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