**Physician’s Assignment and Release**

INFORMED CONSENT FOR TREATMENT: I, the patient/guarantor, agree and consent to participate in behavioral health care services offered by Greater Orlando Psychiatric Associates, P.A. I understand that I am consenting and agreeing only to those services that the above-named group’s providers are qualified to provide within (1) the scope of the provider’s license, certification, and training; or (2) the scope of the license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

RELEASE OF INFORMATION: The undersigned hereby authorizes any Physician/Nurse Practioner/Therapist who have attended the patient to furnish any potentially liable insurance companies or their representatives with any and all information concerning hospitalization, treatment, interpretation, and/or examination that may be contained in their medical records.

ASSIGNMENT OF INSURANCE BENEFITS: As undersigned, I hereby authorize direct payment to any involved Healthcare Providers of the benefits otherwise payable to the patient or guarantor. I also assign any and all rights to insurance coverage relative to this treatment, but not to exceed the regular charges for consultation, treatment, interpretation, and/or examination.

FINANCIAL RESPONSIBILITY: As the undersigned, I understand that I am responsible for any service rendered by a Physician/Therapist, regardless of whether this service is covered by an insurance policy. I understand that payment is due at the time of service unless other arrangements have been made in advance. The accepted methods of payment are Cash, Check (processed electronically), Visa, Mastercard, and Discover. If my insurance companies require pre-certification, I understand that I am responsible for obtaining the initial authorization.

**Missed appointments or appointments not canceled with at least one business day in advance will be assessed a fee of $25.00.**

CONFIRMATION OF APPOINTMENTS: Patients seeking to attend any appointments via telehealth will need to consent to receiving appointment reminders by e-mail or text message, in order to receive a URL link for an appointment. Consent may be revoked at any time by notifying the office. I consent to receiving appointment reminders by the following method (s):

\_\_ Phone call/voice message: ( \_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Text (SMS) message: ( \_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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