AUTHORIZATION FOR TREATMENT
ASSIGNMENT OF INSURANCE BENEFITS
RELEASE OF MEDICAL INFORMATION

MERCYLAND PSYCHIATRY
530 W. Main St., Sun Prairie, WI 53590

Last name: _____ First name: _____

Birthdate: _____

Aside from the treatment and services you will receive at Mercyland Psychiatry there are some points that we would like to bring to your attention. You should be familiar with and understand the following prior to committing yourself to treatment. Each item should be discussed with you by your provider. If you have any questions, please ask them.

1. Confidentiality: We want you to know that anything you discuss in our office is considered confidential. You should be comfortable discussing your concerns and problems. We cannot share your information with others without your written consent. The exceptions and/or limits to the confidentiality include but are not limited to suspected abuse and/or neglect, threats of suicide, or physical violence, and when the courts subpoena your records.

2. Insurance: Diagnosis and/or billing code number and dates of outpatient treatment sessions will be provided to your insurance carrier for billing purposes. By signing this authorization, you give us permission to do this.

3. Rights: Please read the **Patient Bill of Rights** document carefully. It outlines your rights in more detail.

4. Complaints: You have the right to voice your complaints regarding your treatment, provider, billing, or other matters.

5. Fees: The cost of your treatment is detailed in the Fee Sheet. We ask that you discuss any fee or billing concerns you have with your provider.

6. Appointments: Your provider will ask you to make appointments at times that are convenient to you. Any cancellation should be made at least 24 hours before your scheduled appointment time. Failure to do so will result in your being charged one-half the provider's normal fee for a 1 hour session. You may be directly responsible for this fee because insurance companies typically do not pay for missed appointments.

Consent: I freely consent to the treatment offered me by the staff of Mercyland Psychiatry. I am aware of my rights as a patient. I am aware that this authorization will remain in effect while I am in treatment and until payment of services is completed. I understand that I can withdraw this consent at any time by submitting my request in writing.

_____ _____

Patient/Guardian Signature Date Time

_____ _____

Witness Signature Date Time