CONSENT FOR DIAGNOSIS AND TREATMENT

Patient:_____ Chart #_____

I hereby authorize authorities of Bay Pointe Behavioral Health Services, Inc., and the doctor in charge of (the, my) case to administer such medications and perform such procedures as may be deemed necessary for the interest and care of: -

_____

(Name of Patient)

_____

Patient/other legally responsible person (Legal relationship to patient)

INITIALS

Reason patient is unable to sign: _____

_____

Address City State Zip

Emergency Phone Calls:

In the event of an emergency, call 911. For non-emergent calls, please call (281) 480-2400

Appointments and Billing:

PICTURE ID AND INSURANCE CARD(s) MUST BE PRESENTED AT EVERY VISIT

Please be aware that you are responsible for payment of your deductible, co-payment, and/or any other charges for service rendered that are not covered by your insurance.

You will be required to make your co-payment, unpaid charges, and/or deductible prior to being seen.

If you are unable to do so, you will be required to reschedule your appointment unless other arrangements for payment are made.

To Cancel an Appointment:

- Call (281) 480-2400 during normal business hours (Monday-Friday, 8 a.m. to 5 p.m., excluding holidays) at least 24 hours before your scheduled appointment.
- You must clearly state you are canceling your appointment and give the date and time of the scheduled appointment.
- Please record the name of the person who canceled your appointment, the date you called, and the time. You may be asked for this information if you call at a later date with questions regarding your appointment or rescheduling.
- If you do not cancel your appointment 24 hours in advance, you will receive a bill for the appointment. Insurance companies do not cover the cost of missed appointments and other charges; therefore, the entire cost will be your financial responsibility.
- Multiple cancellations in less than 24 hours and No Shows may cause your provider-patient relationship to end.
- If you have not been seen in over 6 months, your provider-patient relationship has ended.
    - Provider-patient relationship may resume once you are seen in our office by a provider.

As of January 1, 2014 the following charges will go into effect for all patients of Bay Pointe Behavioral Health Service, Inc.:

SERVICE:	CHARGE:
LETTERS	$150.00 per page
PHONE CALLS THAT REQUIRE CONTACT WITH DOCTOR (GIVE 24 HOURS FOR RETURNED PHONE CALLS)	$5.00 contact fee; plus $2.00 per minute
PHONE CALLS THAT REQUIRE CONTACT WITH DOCTOR ON WEEKENDS, HOLIDAYS, AND AFTER 5:00 P.M.	$20.00 contact fee; plus $5.00 per minute
CONFERENCE CALLS	$150.00 per 20 minutes
FORMS	$150.00 (1-3 pages); $10 per/page (for consecutive pages)
LOST / REWRITTEN PRECRIPTION	$20.00
CII PRESCRIPTION REFILL WITHOUT AN APPOINTMENT	$10.00
CANCELLED APPOINTMENT (WITHIN 24 HOURS)	$40.00
CANCELLED APPOINTMENT WITHOUT NOTICE	$60.00
NEW VISITS	$330.00 / $250.00 PROMPT PAY
ESTABLISHED VISIT FOLLOW-UP	$230.00 / $150.00 PROMPT PAY
PRIOR AUTHORIZATIONS	$25.00

INITIALS

***FOR LETTERS, FORMS, AND MEDICATIONS, PLEASE MAKE YOUR REQUEST 7 DAYS IN ADVANCE ***

If you have not been seen in our office by one of our providers in over 3 months, you may NOT receive a refill.

The services listed above will be billed directly to you. All fees are due prior to point of service. If other charges apply, you will be informed prior to service.

_____ _____ _____ _____

Patient Signature (Patients over 18) **Date** **Parent/Guardian Signature** **Date**

_____ _____

Witness **Date**

Bay Pointe Behavioral Health Service, Inc.

Child ● Adolescent ● Adult Psychiatry

STATEMENT OF PATIENTS' RIGHTS

- ~ Every patient will be provided a written statement of patient rights and responsibilities at the time of the first appointment.
- ~ Every patient will be treated with dignity and respect.
- ~ Every patient will be assured that all patient information is kept confidential.
- ~ Every patient will be afforded all of his rights and privileges guaranteed by State and Federal laws.
- ~ Every patient has the right to know the name, professional status and function of those behavioral health care practitioners involved in his/her care and treatment.
- ~ Every patient will be provided with a complete, easily understood explanation of his/her condition.
- ~ Every patient will receive assistance with respect to knowing and understanding his/her benefits.
- ~ Every patient will be involved in decisions involving his/her treatment.
- ~ Every patient will be informed of the consequences of refusing treatment and/or not complying with prescribed treatment.
- ~ Every patient will be informed of the complaint, grievance and appeal processes should a dispute arise over treatment and/or claims.
- ~ Every patient will be afforded every reasonable consideration to accommodate his/her cultural, language or gender preferences.
- ~ Every patient will be provided with sufficient information to enable him/her to render informed consent to treatment except in emergencies.

INITIALS

IMPORTANT NOTICE ABOUT LABORATORY SCREENINGS

Some insurance companies and plans require that laboratory screenings (blood work, urine screens, etc.) be done only by certain companies. If your doctor prescribes laboratory work, check with your insurance company to see if there is a specific lab provider you must use. Lab requisition forms are available for both Lab Corp and Quest Diagnostic.

INITIALS

I have received this notice and understand that it is my responsibility to check with my insurance company before having laboratory work done.

CONSENT FOR RELEASE OF PATIENT INFORMATION FOR REIMBURSEMENT AND CONTINUITY OF CARE

I authorize Bay Pointe Behavioral Health Service, Inc. to release such social, demographic and diagnostic and therapeutic (including any treatment or test results for alcohol and/or drug abuse, or reportable communicable disease, including Acquired Immune Deficiency Syndrome or Human Immune-deficiency Virus Infection) for this period of inpatient hospitalization or outpatient treatment for one year from the date of this authorization to the following:

- My insurance carriers(s), the Social Security Administration, its intermediaries or carriers, or any party that is or may be liable for all or part of the hospital and and/or physician charges as may be necessary for the purpose of enabling the insurance carrier(s) or Social Security Administration to determine the benefits available to me for the services rendered by Bay Pointe Behavioral Health Service, Inc.
- Individuals, agencies, or facilities working with Bay Pointe Behavioral Health Service, Inc. staff as may be necessary to assist me with Discharge planning.
- The Social Security Administration and/or the Texas Rehabilitation Commission, if applicable, for use in determining my eligibility for disability benefits.
- I further authorize Bay Pointe Behavioral Health Service, Inc. to disclose patient-identifiable information about me for the purposes of seeking reimbursement assistance or for enrolling me in pharmaceutical patient assistance programs that may provide certain products free of charge or at a reduced rate. I understand that, in order to obtain reimbursement assistance or to determine my eligibility to participate in patient assistance programs, certain information about me, including, without limitation, the type and date of my medical diagnosis and treatment, my family income and my health insurance will need to be provided by Bay Pointe Behavioral Health Service, Inc. to the pharmaceutical manufacturer(s) or their agent(s) for the product(s) prescribed to treat my condition. I understand this information will not be used for any other purposes than that as described above.

INITIALS

I further authorize the use of photographic reproduction of this authorization in place of the original.
I understand that I may withdraw this authorization at any time but must do so in writing.

Patient Signature (Patients over 18)	Date	Parent/Guardian Signature	Date

Witness	Date

13310 Beamer Rd., Suite G, Houston, Texas 77089 ● Phone: (281) 480-2400 ● Facsimile: (281) 480-2407