Psychiatry and Holistic Health Center
200 Cordwainer Dr., Ste. 304. Norwell, MA 02061
781.546.2968 (P) / 339.788.9431 (F)

Consent for Services and Treatment

1. I am providing informed consent, meaning that I have thoroughly discussed the risks and benefits of treatment with my provider today and choose to continue treatment with my provider.

2. I understand that my provider has the right to prescribe or NOT prescribe any medications as my provider sees clinically appropriate.

3. I understand that if I am receiving controlled substance prescriptions, I must receive my prescriptions from my provider, in person, at least monthly, until we decide otherwise together.

4. I understand that any charges that are denied, rejected, or not covered by insurance are my financial responsibility.

5. I understand that all patients are required to keep an active credit card on file, and that patient (or guarantor) SSN is required for billing purposes only.

6. I understand that payment for services, including any co-pays/deductibles/co-insurance/self-pay, is due as soon as a balance is accrued.

7. I understand that I will owe $150 for any requests to reschedule, missed appointments, or cancellations with less than **48 business hours** notice. I understand that I will owe this rescheduling fee ***out of pocket***. I understand I may be terminated as a client for more than **three** missed appointments.

8. I understand that it is my responsibility as the patient to be aware of any deductibles, copay/coinsurance, and any other out-of-pocket expenses I may incur.

9. If applicable, I have been informed of the self-pay rates. These may be subject to change. I understand that I will be notified ahead of time before any increase in rates.

10. I have received a copy of HIPAA compliance regulations and how to access more information on HIPAA.

11. I understand that Psychiatry and Holistic Health Center will not disclose any information about me or my treatment here, or the fact that I am a patient here, without my written consent.

12. However, I understand that my protected health information (PHI) may be shared to carry out treatment, payment, and healthcare operations; and my PHI may be shared without my authorization in cases of emergency, child or elderly abuse, serious threat of self-harm or harm to others, and for certain legal matters.

13. I understand that Psychiatry and Holistic Health Center does not provide any emergency care and that I am to call 911 if I need emergency care.

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14. I understand that I may be terminated as a client of Psychiatry and Holistic Health Center at any time for any reason that my provider sees as appropriate and that I may terminate my care with Psychiatry and Holistic Health Center at any time. Upon termination, I understand that I may be provided with no more than a 90-day supply of medication refills.

15. I understand that this is a teaching clinic, so there may be students, interns, and/or supervisors present during my appointments. I also understand that I may be working primarily with a student or intern, but that their supervisor may intervene as needed. I understand that these students and interns are fully supervised by independently and fully licensed senior providers.