Silver Psychiatric Services, PC

Patient Information/Consent to Treat

	Date:
Patient Name:	Referring Doc:
Address:	Referring Doc Phone:
city/state/zip	Primary Doctor:
H# C#	Employer/School
Date of Birth: Marital Status:	Email:
Insurance Company:	Insurance ID#
Emergency Contact: Relationship:	H# C#
Responsible Party: Relationship:	Date of Birth:
Responsible Party Address:	H# C#
Parents/Guardian contact info (for minors):	H# C#

Please Initial below all areas below that you have read and that you agree:

________**Financial Responsibility:**
I guarantee payment to Silver Psychiatric Services of all services provided to the patient. I understand that I am personally responsible for all charges regardless of insurance benefit coverage. I am aware that payment is due at the time of service. Silver Psychiatric Services does not take any insurance, **including Medicaid and Medicare and beneficiaries are not able to submit claims to Medicaid/Medicare for reimbursement. Patient is responsible to notify Dr. Schacter's office of any changes in insurance, address and/or contact information.**

_________**Consent for Healthcare:**
I voluntarily consent to healthcare treatment from the physician and staff at Silver Psychiatric Services. I consent to any lab work including HIV testing. I am aware that the act of medicine is not an exact science. No guarantees have been made to me regarding the results of treatment or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

_________**Acknowledgement of Receipt of Joint Notice of Privacy Practices:**
I have been offered/received a copy of the Silver Psychiatric Services Joint Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice on the Silver Psychiatric Website at http://silverpsychiatric.com/NPP_Sum-hippa.pdf or by inquiring at the office.

These Authorizations will remain in effect until revoked by the patient.

Signature of Patient/Authorized Person: ____ **Date/Time:**_________________________________

Name of Authorized person: ____ **Parent/guardian/other**_________________________________

Updated 12/9/2020