Consent for Treatment

C2 Your Health, PC

8720 Forest Hill Avenue
North Chesterfield, VA 23235
P: 804-325-1669, F: 804-325-1670

Informed Consent: Please read and sign this consent for treatment. If you have any questions regarding its content, please discuss with your provider prior to signing this form.

I give my consent for treatment related services with C2 Your Health, PC and associated staff which may include evaluation, psychotherapy, medication, and the treatment planning process. I have had the opportunity to read, review, and ask questions about the C2 Your Health Notice of Privacy Practices (available on the website and posted in the waiting room), and am aware I may ask for a copy of it at any time. I am aware of my provider's procedures for afterhours mental health emergencies.

If the patient is a minor and the custodial parents/guardians are separated, divorced, or have separate housing arrangements, I understand the following:

- All legal guardians must give verbal agreement for treatment.
- My provider may require agreement for treatment from a parent even if that parent does not have legal custody of the patient.
- C2 Your Health staff and providers may release Protected Health Information regarding the patient's care to the other parent even if that other parent does not have legal custody. However, Protected Health Information would not be released (without consent from the legal guardian) to a parent whose parental rights have been terminated.

Payment Policy: I have reviewed and agree to the list of professional fees posted by my provider(s). These charges may include fees for evaluation, ongoing treatment, missed appointments, telephone calls lasting more than 5 minutes, written letters or forms, copy fees, court testimony, charges for transportation and preparation related to court testimony, and returned checks. If my account is referred to an attorney or collector, I am responsible for all additional fees incurred.

If my provider at C2 Your Health, PC, is accepting insurance reimbursement for my treatment, I understand my insurance claims are filed as a courtesy and I am ultimately responsible for any charges for services provided by C2 Your Health, PC. I understand that not all services are covered by my insurance plan.

- I authorize the release of any medical or other information necessary to process this claim
- I authorize payment of medical benefits directly to my treatment provider(s) for services they provide
- I recognize that I am responsible for any unreimbursed portions of my treatment. In the event my insurance does not pay within 45 days for the date the claim is filed I will pay the balance in full or make a reasonable payment arrangement

Insurance: If you consent to C2 Your Health, PC filing for insurance reimbursement for your / your child's treatment, please provide the following information. *If your provider does not accept insurance reimbursement or does not accept your insurance, please skip this section*.

Insurance Company: _____ Plan Name: _____

Policy Holder's Name: _____ Relationship to patient: _____

Policy Holder DOB: _____/_____/_____ Policy Number: _____

Group Number (if applicable): _____ Social Security Number: _____

Employer: _____

(Please provide a copy of your insurance card if using insurance)

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Communications: I understand that C2 Your Health may need to contact me. I agree to the following forms of communication, knowing that C2 Your Health staff will identify themselves and leave information about my / my child's care and appointments. Check off which forms of communication you agree to below:

Phone calls to: ____ Cell phone ____ Home phone ____ Work phone

____ Email: _____

____ I consent to online or "virtual" appointments

____ I consent to texting to my cell phone

RELEASE OF INFORMATION TO PRIMARY CARE PROVIDER

It is generally standard practice that your provider shares treatment information with your primary care provider to facilitate coordination of care. Insurance companies also may require that your provider share treatment information with your primary care provider. We ask that you authorize or decline this communication.

_____ I give permission to C2 Your Health to release treatment information regarding myself / my child to the primary care provider listed below. I understand that this release shall be valid for ninety (90) days after my last date of treatment. I understand that I may revoke this authorization at any time during the course of my treatment.

_____ I do not authorize C2 Your Health to release treatment information to my / my child's primary care provider.

_____ I additionally give permission to C2 Your Health to release treatment information to the additional professional listed below for the purposes of coordination of my / my child's treatment.

_____ _____

Primary Care Physician Phone number

_____ _____

Other Treatment Provider Phone number

_____ _____

Patient or Guardian Signature Date

Prescription Monitoring Program: If I am treated with medications by a medical provider at C2 Your Health, I consent to my provider using the Virginia Prescription Monitoring Program as my provider deems appropriate to confirm medication prescription history.

Your signature below indicates: You give your consent for clinical and/or court related services with C2 Your Health and that you have read this Consent for Treatment Agreement and agree to its terms.

Patient: _____ Guardian (if minor patient): _____

(please print) *(please print)*

Signature: _____ Date: _____