

Today's date:		
Patient's last name:	First:	Middle:

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Tracey Marks, MD of Marks Psychiatry and Forensic Services (MPFS) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Marks Psychiatry and Forensic Services. I understand that diagnosis or treatment of me by Dr. Marks may be conditioned upon my consent as evidenced by my signature on this document. **I am also consenting to allow Dr. Marks to communicate with pharmacies about my medication (if applicable).**

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr. Marks is not required to agree to the restrictions that I may request. However, if Dr. Marks agrees to a restriction that I request, the restriction is binding of Dr. Marks.

I have the right to revoke this consent in writing, at any time, except to the extent that Dr. Marks has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by Dr. Marks, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand Dr. Marks' Notice of Privacy Practices has been made available to me prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Marks.

Dr. Marks reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Dr. Marks' website, www.markspsychiatry.com, calling the office and requesting a copy be sent to me by mail, or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative		Date
Name of Patient or Personal Representative (printed)	Relationship to Patient	

FINANCIAL RESPONSIBILITY

(Skip this section if you are undergoing an Independent Medical Evaluation)

Person responsible for bill (if not patient):	Relationship to Patient:	Address (if different):	Home phone no.: ()
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I understand that I am financially responsible for all charges generated by this patient regardless of the patient's insurance coverage. Office policy requires payment at the time of service. If Dr. Marks is a provider for my insurance plan, I will pay the co-payment at the time of service and Dr. Marks will bill my insurance for the balance. I authorize my insurance benefits be paid directly to Dr. Marks. However, if Dr. Marks renders a service that is not covered by my insurance, I understand I am responsible for the full payment and will pay within 30 days of notification. I understand

that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% of that outstanding balance. Examples of uncovered services are telephone sessions, missed appointments, psychological testing, and legal evaluations such as Independent Medical Evaluations or Forensic evaluations. My signature below confirms agreement with the above statements.

Signature	Print name		Date

PATIENT POLICIES

Emergencies:

Call my answering service at 770-928-5301 and ask that Dr. Marks be paged. On weekends and holidays, Dr. Marks may be covered by another physician who answers your call. If you can not wait for Dr. Marks or her covering physician to answer your call, please call 911 or go to your nearest emergency room for an evaluation.

Payment Policy:

Patients are responsible for their charges. Payments are requested at the time of each visit unless otherwise arranged in advance. There will be a 1.5% monthly charge for balances over thirty (30) days. If you have insurance and opt to see Dr. Marks as an out of network provider, Dr. Marks can provide you with the necessary information to submit to your insurance company.

Appointment Changes/Cancellations:

Patients will be charged for appointments unless cancelled within twenty four (24) business hours. Dr. Marks understands that emergencies occur and therefore the first "no show" will be excused and you will not be required to pay for the session. However, subsequent missed appointments will be charged at the full session rate. All cancellations must be made during office hours (Monday through Friday 8:30am – 5:00pm). Please note, most insurance companies do not pay for missed appointments. You will not be charged for appointment changes initiated by Dr. Marks.

Miscellaneous Charges:

There will be a nominal charge for records requests. The charge covers the cost to duplicate the records and postage. There may be a charge for reports/letters sent on your behalf. The minimum charge is \$25 and possibly more depending on extent of the information needed and length of the letter/report generated.

Telephone and Email Policy:

Dr. Marks routinely returns calls made between 8:30 and 4pm by the end of the day. If they are not returned by 5pm, they will be returned within twenty-four hours. Phone calls returned by Dr. Marks are for brief issues such as medication questions, appointment changes etc. For more extensive calls, please schedule a phone appointment. Phone appointments will be charged based on the session time 25 min – 50 min. Be advised, most insurance companies do not pay for phone sessions.

Email correspondence is similar to phone in that it is for brief, administrative issues. You can also make medication refill requests through the website at www.markspsychiatry.com The website and email are secured, however it is not foolproof against computer hackers. Therefore be cautious as to how much personal information you send via email, especially if your email server is not secure.

Dr. Tracey Marks strives to provide quality psychiatry care to all patients. Please feel free to discuss the patient policies with Dr. Marks prior to signing the form.

My signature below indicates I have read and accept the above patient policies.

Patient's signature	Guardian if a Minor		Date