Consent to Use and Disclose your Health Information

This form is an agreement between you _____, and me, Dr. Elizabeth Ellis. When we use the word "you" below, it will mean your child if you have his or her name here _____.

When we examine, diagnose, treat, provide consultation, evaluate, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide what treatment is best for you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment. By signing this form you are agreeing to let us use your information here to send a claim to your health insurance plan. The Notice of Privacy Practices (the short form is on the "Welcome to the Practice" sheet) explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form. If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot provide services to you.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us in writing what you want. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wishes. After you have signed this consent form, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client (or parent) (Date)

(If I am a divorced parent, giving consent to treatment for my child, I assert that I have sole or joint legal custody of my child and have the right to seek treatment for my child. I also assert that I have complied with any notification requirement listed in my divorce agreement).

_____

Signature of client (or parent)

Consent to Office Policies

I understand that not all services that are provided at this office are covered by all health plans. I understand that I am responsible for any deductibles that haven't been met, for all co-payments, and for all non-covered services. I understand that I will be charged $65.00 for hour-long appointments that are cancelled less than 48 hours in advance, ($75.00 for PRIME TIME appointments cancelled less than 2 business days ahead). Appointments for a 90 minute or 2 hour block of time must be cancelled 4 business days in advance. The missed appointment fee for those appointments will be $95 and $120, respectively. If I learn that I am suddenly not able to keep an appointment, I will try to call as soon as possible so that the office can attempt to offer my appointment to someone else. If the appointment time is then filled, I will not be charged.

_____

Signature of client (or parent) 11/09