CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, & HEALTHCARE OPERATIONS

DEBALZO, ELGUDIN, LEVINE, RISEN LLC (DELR)

I, _____, a patient of DELR or guardian of a patient of DELR, indicate that:

I have read, understand, and agree to the information and terms in the DELR Notice of Privacy Practices and have received a copy of the Notice of Privacy Practices. **(Consent to Privacy Practices Notice**),

I authorize DELR and its employees to provide mental health care for me or the patient I am legal guardian for, which may include but is not limited to assessment of my condition, psychotherapy, medication treatment/management, diagnostic testing, group therapy, marital and/or family therapy, psychological testing, counseling and supportive care for mental health or alcohol/drug related conditions. This consent also includes contact and discussion with other healthcare professionals necessary for my care and treatment. **(Consent to Treatment)**

I authorize DELR to furnish information to my identified insurance carrier(s) for any and all medical payment activities. I consent to the use of any operational practices to facilitate insurance payment of my medical claims per the Notice of Privacy Practices. I understand that my medical record includes my demographic information (name, date of birth, social security number, address, marital status), psychiatric and medical diagnoses, type and duration of treatment and that this information is routinely requested and shared with insurance companies as part of the billing process. **(Consent for Release of Information for Payment & Treatment)**

I understand that DELR may refuse to provide services to me if I refuse to sign this consent. I understand that I may revoke this consent at any time and that at that time DELR may refuse to provide further services to me. I understand that if I revoke this consent, the revocation will not take effect until it is received in writing or signature below. **(Refusal/Revocation of Consent)**

Patient Name (Print)_____

Signature Patient/Guardian_____ Date_____

REFUSAL/REVOCATION OF CONSENT: As of this date _____, under no circumstances do I wish any of my personal healthcare information to be shared with others including insurance companies and other healthcare professionals.

Patient Name (Print)_____

Signature Patient/Guardian_____ Date_____