#

# Consent for Services and Communication

## Psychiatric Services ● Email & Text

**I, the undersigned, expressly consent to my (the patient’s) medical treatment, including:**

1. I authorize the healthcare professionals of Integrated Psychiatry PLLC and their designees and business associates, to administer medical tests, diagnostic procedures, and perform treatment, as well as view Sure Scripts, as considered medically or therapeutically necessary.

2. I understand that Integrated Psychiatry PLLC may share medical information with the health insurance company(ies) I have identified as providing me with coverage, as may be necessary to process claims for medical services rendered to me.

3. I authorize payment of health insurance benefits to Integrated Psychiatry PLLC for medical services rendered to me.

4. I understand that more detailed information about my rights as a patient, and the way my medical information may be used or released, is described in Integrated Psychiatry PLLC Notice of Privacy Practices and that Integrated Psychiatry PLLC’s Notice of Privacy Practices has been made available to me.

**For psychiatric treatment, where applicable, I agree and understand that:**

1. Treatment may include prescription and monitoring of psychotropic medications, lab monitoring, referral, psychoeducation, sleep hygiene, brief psychotherapy, and other necessary treatments.

2. I acknowledge Integrated Psychiatry PLLC cannot guarantee me specific results of psychiatric tests, treatments, or any other services rendered.

3. I understand my psychiatrist and/or pharmacist will provide me with information about known side-effects of any medication administered or prescribed.

4. I am aware there are exceptions to confidentiality of psychiatric records, as described in the Notice of Privacy Practices. These include but are not limited to:

* The Integrated Psychiatry PLLC staff work as a team. My psychiatric provider may consult with another Integrated Psychiatry PLLC provider, a consulting psychiatrist, or a family practice provider to provide me with the best possible care.
* If I pose a threat of harm to myself and/or others, Integrated Psychiatry PLLC will take whatever steps are required or permitted by law to help prevent the harm from happening.

**For phone, email, and text messaging I agree and understand that:**

1. Integrated Psychiatry PLLC will use the contact information I have provided the office, including phone, address, and email address.

2. Integrated Psychiatry PLLC may leave detailed appointment, medical care, test results, and billing information on voicemails at the phone number I provide so long as the voicemail identifies me as the owner. Detailed messages will not be left on unidentified devices.

3. For my security and convenience, Integrated Psychiatry PLLC offers to communicate with me via the patient portal, however, if I prefer Integrated Psychiatry PLLC use an alternate email address (e.g., my personal email account), additional steps on my end may be necessary to access and read any emails sent to such external accounts.

4. For my convenience, Integrated Psychiatry PLLC also offers me a choice of receiving text messages to remind me of upcoming appointments and/or care coordination activities. Integrated Psychiatry PLLC limits information sent via text message to the minimum necessary.

5. I also understand that:

* Integrated Psychiatry PLLC considers all patient medical information as confidential. However, email users should never consider electronic communications to be entirely private or secure.
* Integrated Psychiatry PLLC strongly recommends that email communications be sent from and received via my patient portal account.
* I should NOT use email for any emergency situation or when an immediate or urgent response is needed.
* I have the choice to “opt out” of receiving communications from Integrated Psychiatry PLLC via email and/or text.

**Further, I agree and understand that:**

1. I may be contacted for additional information regarding my health care or insurance coverage by Integrated Psychiatry PLLC.

2. I am responsible for, and agree to pay, all charges that exceed or are not covered by my health insurance coverage.

3. I understand that if the charges remain unpaid, I will need to reconcile the charges in order to be unable to continue receiving Integrated Psychiatry PLLC provider services.

4. I intend this consent to remain in effect, so long as I am a patient of Integrated Psychiatry PLLC. However, I understand I may withdraw this consent in writing.

5. My withdrawal will not be effective for actions already taken (or in the process of being taken) by Integrated Psychiatry PLLC.

6. If I am under age 18, my parent or legal representative must sign this form consenting to medical care on my behalf with the exception of the following types of healthcare that by Iowa law I am able to consent for myself:

* Emergency Care
* Contraceptive Services
* HIV/AIDS Care
	+ Sexually Transmitted Infection prevention, diagnosis & treatment
	+ Substance Abuse Treatment
	+ Tobacco Cessation
	+ Victim Medical and Mental Health Services

**Terms of Acceptance and Signature**: I accept and understand that by typing my name here, I am signing this Agreement electronically. I agree and understand that my electronic signature is the legal equivalent of my handwritten signature and that I am legally bound by the terms contained in this document.

BY SIGNING THIS I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE POLICIES ABOVE

Patient Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Legal Representative (if patient under age 18) and Relation to Patient (e.g., Mother, Father, Guardian, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_