Patient Service Agreement and Consent Form

ACHIEVE Psychiatric Wellness Center LLC ("Provider") is proud to provide you with personalized support and care. Please read and sign the following agreement; it lists our billing, scheduling and cancellation policies and procedures. If you have any questions, please ask for clarification.

A. **Scheduling Services.** All services can be scheduled by using Alma's website, by calling Provider at 855-PSY-WELL or by emailing Provider at achievepsychiatric@gmail.com. [If you schedule an appointment or communicate with Provider via email, you are consenting for Provider to respond to your email utilizing the same method, even if you have not completed the email and text consent you will receive in conjunction with this Agreement.

B. **Cost of Services.** Provider's rate for a 60 minute psychiatric diagnostic evaluation with or without prescription medication is $250.00. If the Provider is in-network, your health insurance will be billed directly. You are responsible for any copays, cost shares, or deductibles.

C. **Services.** You agree to receive psychiatric services (the "Services") which may involve the use of psychotherapy, prescription medication, over-the-counter medications, supplements, and referrals You understand the risks, benefits and alternatives of receiving these Services and have had the opportunity to ask questions.

D. **Payment Methods.** You understand and agree that payment for services shall be made at the time of service. Provider accepts payment in the form of cash, check, or credit card. If you will be using insurance to cover some or all of the cost of your appointment, you should contact Provider ahead of your appointment to ensure your insurance is accepted, and bring your insurance card with you to your appointment. You should be prepared to pay any co-payments at the time of the appointment with either cash or check or credit card. If Provider is out of network for your insurance, Provider will submit an out-of-network claim on your behalf, but you must be prepared to pay in full for your appointment at the time of service, with either cash or check or credit card.

E. **Cancellation Policy.** You understand that your appointment must be canceled at least [twenty-four (24)] hours in advance or you will be responsible for full payment for the missed visit. Please note, most insurance companies will not pay for a missed visit on your behalf.

F. **Confidentiality and Compliance.** Provider will take appropriate precautions to keep your health information confidential and to not disclose it without your consent. You are also protected under the provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) and any other applicable federal and state laws related to protection of patient information, including but not limited to Public Health Law § 18. There are certain exceptions to when your confidential information would not be protected—for instance, if Provider believes that you will harm yourself or another person or are neglecting or abusing a child or a vulnerable adult.

G. **Waiver of Liability.** By signing this Agreement, you agree to waive, release and discharge Provider from any and all liability, including, without limitation, any injuries that may occur during the provision of services under this Agreement.

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Acknowledgement and Agreement

I, _____, have read and understand the information provided above, and understand and agree to the terms in this Agreement, including costs of Services, payment methods and cancellation policy. Any questions I had have been answered.

Patient Signature: _____

Print Name: _____

Date: _____