Hope, Healing & Holistic Psychiatry

Nicole L. Flanagan, PMHNP-BC, MSN, RN, BA

Consent to Treat / Authorization to Release Medical Information / Assignment of Benefits / Notice of Privacy Practices / Notice of "Right To Receive Good Faith Estimate of Expected Charges" under "The No Surprises Act"

(Patient/Legal guardian to INITIAL *each section* below and sign bottom of form)

1. **CONSENT TO BASIC TREATMENT:** "This is to certify that I, _____**(Print NAME)**, consent to the administration of treatment to the above named patient by Nicole L. Flanagan, PMHNP, or any provider under contract with them. I consent to any medical procedures of examination and any other service rendered to me. I understand that, except in emergency, all procedures, will be discussed with me by my physician and that an additional specific consent form may be required. Unless revoked in writing, this permission will be good for one year." _____**(INITIALS)**

2. **CONSENT TO TELEMEDICINE TREATMENT WITH AI SUPPORT:** "I consent to telehealth treatment with AI support with the understanding that there are potential risks and benefits associated with psychiatric treatment and that I will be exchanging confidential information with my provider through interactive audio, video, and/or data communication visually and/or orally. I further understand that HIPAA guidelines apply, supporting the same privacy to me as office visits would, although there are risks during transmission that can be impacted by technical failures, interruptions due to my choice of appointment location and possible interceptions by unauthorized persons. I also understand that I may withdraw consent for this at any time by notifying my provider or office staff." _____**(INITIALS)**

3. **AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** "I consent to allow Nicole L. Flanagan, PMHNP, as defined above, to use and disclose my protected health information with Nicole L. Flanagan, PMHNP, to carry out my treatment, to obtain payment and to carry out health care operations. My protected health care information may be disclosed to my health plan and/or it's agents as necessary to verify benefits, authorize services, and process medical claims. My protected health information may be disclosed to outside health agencies or institutions involved in my continuing care when I am transferred to another facility and/or for emergency care purposes. My physician may also share my information with referring physicians for continuing care as deemed appropriate by me. My protected health information may include medical information or any information pertaining to the examination, treatment, history, which may include Psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical information and charges to my health plan and/or their acting intermediaries and/or agents. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it; withdrawal of consent shall be addressed in writing to the Director of Medical Records." _____**(INITIALS)**

4. **ASSIGNMENT OF BENEFITS:** "I authorize my health plan to pay benefits directly to Nicole L. Flanagan, PMHNP, or any provider under contract with them. I understand that in the event my health plan or healthcare contract does not cover services, I will be responsible for payment. Examples include co-payments, deductible, charges considered beyond usual, customary, and reasonable or uncovered services." **NON-ASSIGNMENT OF BENEFITS OR SELF-PAY:** "I understand that if my health plan does not consider Nicole L. Flanagan, PMHNP, or any other provider under contract with them, a participating provider, charges incurred will be paid by me. I understand that I will be charged $50.00 for appointments that I have not cancelled at least 24 hours in advance. I understand that my health insurance provider will not reimburse for missed appointments. I further agree to accept full financial responsibility for payment of charges rendered to the above patient." _____**(INITIALS)**

5. **NOTICE OF PRIVACY PRACTICES:** "I understand that specific information regarding the uses and disclosures of my medical information can be found in the Nicole L. Flanagan, PMHNP, Notice of Privacy Practices which has been provided to me and which I have a right to review before I sign this. I further understand that Nicole L. Flanagan, PMHNP, has a right to change its Notice of Privacy Practices. I understand that I have a right to request that Nicole L. Flanagan, PMHNP, restrict how my protected health information is used and disclosed for treatment, payment and health care operations. I further understand that Nicole L. Flanagan, PMHNP, is not required to agree to my requested restrictions. However, if Nicole L. Flanagan, PMHNP, agrees to a requested restriction, it is bound by it." _____**(INITIALS)**

6. **CONSENT TO COORDINATION OF MEDICAL CARE:** "I understand That the best way to provide treatment support to me is through coordination of care with other providers, and other medical records, using current technology. I understand and give consent to this provider to review EPIC (electronic medical record coordinated care website) or

Current Care (medical collection website) to access past lab results, discharge summaries and general medical record information to ensure a thorough understanding of my case and my needs. I understand that if I have questions or concerns I may review this with my current provider, in your chart portal for other outpatient providers, or at https://currentcareri.org/patients (Current Care website). I also understand that I may need to sign a release of information for provider to gain access to this information and have the right to restrict access to certain information or revoke access at any time." _____**(INITIALS)**

7. **NOTICE: "RIGHT TO RECEIVE A GOOD FAITH ESTIMATE OF EXPECTED CHARGES" UNDER THE NO SURPRISES ACT:** Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges. _____**(INITIALS)**

SIGNATURE of PATIENT/LEGAL REPRESENTATIVE **DATE** **RELATIONSHIP to PATIENT**

NICOLE L. FLANAGAN, PMHNP - BC **DATE** **TITLE**