OLIVE BRANCH PSYCHIATRY

35 SE 1st Ave Suite 200 O
Ocala, FL 34471
(352)234-3332

Julie Cruse, DNP, APRN, PMHNP-BC

Patient Consent Form

Thank you for choosing Olive Branch Psychiatry (OBP) for your mental health care. This Consent for Psychiatric Care Agreement authorizes OBP to provide your medical are, share your health information, and receive payment for the services provided to you.

- I consent to receiving evaluation, diagnosis, medical care and treatment that is considered necessary or recommended by my provider, including treatment and services in person and through the use of telehealth technologies, such as telephonic and interactive live audio-visual communications. I understand that I may be in a different physical location from the provider due to telehealth services. I understand that no guarantees have been made to me about the result of my evaluation, diagnosis, or treatment.
- I agree that all methods of communication, including telephone numbers, email addresses and physical addresses I provide to OBP may be used by OBP or individuals acting on the behalf of OBP to communicate with me. If I do not wish to receive text messages or telephone calls, I will notify OBP.
- My health information includes diagnostic information, lab testing, medications, allergies, medical records such as a history and physical, progress notes, treatment plans, discharge summary and other records pertaining to my treatment.
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a law which protects the privacy and security of my health information in the United States. There are other federal and state laws that protect "sensitive" health information including health information as defined above relating to HIV/AIDS, behavioral/mental health, developmental disabilities, treatment for substance use disorder (including alcohol and/or drug use), genetic testing and counseling, sexual assault/abuse, domestic abuse of an adult with a disability, child abuse and neglect, sexually transmitted infections, and pregnancy and birth control.
- If my consent is required by law, I allow OBP to use and disclose my sensitive health information to those outside of OBP as needed for treatment, payment (insurance), and care coordination in the same way HIPAA allows OBP to use or disclose my health information for these purposes and as described in the Notice of Privacy Practices.
- I understand that OBP is not responsible for the loss, destruction, or theft of any personal property I bring with me to OBP offices. I take full responsibility and release OBP from responsibility and liability for my personal property.
- I understand I am not allowed to take pictures, or make any video or audio recordings of my care at any time.
- I agree that I am financially responsible for the services I receive at OBP and agree to pay for these services at the rates applicable to the services received. If I choose to have my health insurance reimburse OBP for my medical care, I give permission for OBP to bill any such insurer and update that information as necessary. I understand insurance coverage varies and my insurer may not pay for everything, or only pay for a portion of my bill. I am responsible for any outstanding balance and copayments or deductibles.

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- If OBP does not have an agreement with my insurance provider, I understand I will be responsible for the payment of any services rendered at the time of my visit, and at my request, I will be provided with a bill (called a "superbill") which I may submit to my insurance carrier. I understand I may or may not be reimbursed, and agree to be responsible for any costs not reimbursed to me by my insurance carrier.
- I have read, understand, and agree to this Consent for Psychiatric Care Agreement. I have been given the opportunity to ask questions, and I understand I may contact OBP should I need any additional information.

____________________________________ __________________

Patient or Responsible Party Signature **Date**