

Treatment Consent and Assignment of Benefits

1. I request and give consent for the usual and customary medical treatment provided by Waterstone.
2. I authorize Waterstone to release information necessary to secure payment from my insurance company or in the event that my insurance company requires utilization review or audit, may include a review of my complete record.
3. I authorize direct payment of medical benefits to Waterstone for services rendered.
4. I understand that I am financially responsible for any co-pays, fees, or balances not covered by my insurance company. (Please see Waterstone Financial Agreement for more information.)
5. I understand that Waterstone will maintain my confidentiality per HIPPA regulations, except under certain circumstances required by law, including but not limited to imminent danger to self or others; suspected history of/current physical/sexual abuse or neglect of children or the elderly; or in the event of a medical or psychiatric emergency. (Please see Notice of Privacy Practices for more information).
- 6. I agree to cancel scheduled appointments within 24 hours.**
7. I understand that there are reasons that may result in an involuntary reduction in care or in a discharge from care. Some reasons may be; consistently missing appointments, threatening and/or violent behavior or inability to pay for services as agreed upon in the Waterstone Financial Agreement.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Printed Patient Name _____

Patient Signature _____

Date _____