HIGHPOINT HEALTH

Consolidated Consent for Psych Services

Your signature below indicates that you request and approve the delivery of psych services and agree to all the following terms:

1. Any counseling services you authorize will be rendered by AMG Counseling, Ltd, doing business as "HighPoint Counseling." Any psychiatric services you authorize will be rendered GeroPsych Psychiatry, Ltd, doing business as "HighPoint Psychiatry."

2. You understand that HighPoint Counseling and HighPoint Psychiatry are separately owned franchise companies, and you agree that neither company may be held responsible for the actions of the other.

3. You agree that HighPoint Psychiatry & HighPoint Counseling may bill your insurer for any services they rendered. You understand you may have some out-of-pocket costs like copayments and deductibles. You accept responsibility for understanding your insurance coverage.

4. You have been offered a *HIPAA Notice & Service Agreement.* You attest that you understand and accept all terms set forth in that document. If you misplace your copy, you can download the document at www.HighPoint.health or you can request a replacement by calling (844) PSYCHED. That's (844) 779-2433.

5. You authorize HighPoint Psychiatry and HighPoint Counseling to share your Protected Health Information with each other, with the staff at the facility where you reside, with your loved ones, and with other professionals as described in the *HIPAA Notice & Service Agreement*.

6. You agree that HighPoint Counseling and HighPoint Psychiatry have the right to refuse services at their sole discretion.

7. By authorizing counseling services below, you permit HighPoint Counseling to assign you a mid-level provider who works under the supervision of a Psychologist. Current supervisory relationships are reported in the *HIPAA Notice & Service Agreement*. If you have questions about supervision, you may ask your provider or call (844) 779-2433.

8. Should a request be made, you authorize HighPoint Counseling to complete an Expert Evaluation as described in the *HIPAA Notice & Service Agreement*.

9. You authorize an Intake Evaluation by HighPoint Counseling and the delivery of services indicated below:

Counseling:	_____ Yes	_____ No
Psychiatry:	_____ Yes	_____ No

Any Unmarked Service Shall Be Deemed "Unauthorized"

_____
Patient's Name (**PRINT**)

_____ _____ _____
Legally Responsible Party (**PRINT**) Signature (Verbal Consent Cannot be Accepted) Date

Items needed for a Complete Referral:
Consent Form
Medical Necessity Form (or a Medical Order)
Patient's Face Sheet

Send Items To:
eMail: Referrals@HighPoint.health
Fax: (844) PSYCH-FX
(844) 779-2439

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