Dr. Danielle DeSantis & Associates

Consent to treatment and fee agreement

Client's full name_____DOB_____SS_____

Responsible party_____Phone: Home: _____Cell_____

Address:_____

I hereby agree to assume financial responsibility for payment to Dr. Danielle DeSantis for services provided to me in one of the following ways:

- ☐ I hereby give permission to Dr. Danielle DeSantis & Associates to release information to my insurance company necessary to process claims. I will assume responsibility for all deductibles, copayments, and claims not paid by my insurance company, or unpaid bills due to my failure to provide accurate information in a timely fashion.

- ☐ I do not have or do not wish to use my health insurance and will assume full financial responsibility for payment for the services I receive from Dr. Danielle DeSantis & Associates, due at the time of service.

I understand that my records and communications are confidential with certain legal exceptions and are protected under state and federal laws (including the Health Insurance Portability and Accountability Act, HIPAA, and the Federal Substance Abuse Confidentiality Regulations, 42 CFR Part 2), and cannot be disclosed without my written consent unless otherwise provided for in regulation or law. Dr. DeSantis and I have discussed limitations to my confidentiality rights. I understand that I may revoke this consent at any time and in any case that this consent expires: _____(post date one year).

The practice of behavioral health services is regulated by the Department of Health, Professional Regulations Boards. You can contact Dr. Danielle DeSantis at 401-371-0223 or Professional Regulations at 401-272-2827 with any questions about services, limits of appropriate professional relationships, or about behavioral health regulations in general.

I also understand that Dr. Danielle DeSantis & Associates has a 24 hour cancellation policy. Therefore I will be expected to pay a fee of $90 for any regularly scheduled appointment not canceled 24 hours before the appointment time.

<u>Please initial the following:</u>

___I hereby give Dr. Danielle DeSantis & Associates permission to discuss and/or release records regarding my condition and treatment with _____(my doctor) for the purpose of coordination of treatment.

___I consent for Dr. Danielle DeSantis & Asssociates to offer me behavioral health services as described to me and accept the nature and limits of services available. I agree to be contacted after leaving treatment for evaluation of the services I received.

___I acknowledge that I have received a copy of the HIPAA notice of Policies and Practices.

___I have been given a copy of this agreement

_____ _____

Signature of client Date

_____ _____

Signature of person responsible for payment Date

_____ _____

Witness Date