EUNIQUE MIND & Mental Wellness

Email: admin@euniquemindwellness.com
Phone: (512) 843-2714

A) Patient Consent for Tele Psychiatry treatment

I have the right, as a patient, to be informed about my psychiatric condition(s) and the recommended diagnostic and treatment to be used so that I may make the decision whether or not to undergo any suggested treatment after knowing the risks and hazards involved. At this point in my care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment for any identified condition(s). This consent provides me with your permission to perform reasonable and necessary psychiatric assessments, testing and treatment.

By my verbal consent, I am indicating that:

1. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment is recommended.
2. I consent to treatment at this practice. The consent will remain fully effective until it is revoked by me. I have the right at any time to discontinue services. I have the right to discuss the treatment plan with my provider about the purpose, potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommend by my provider, I am encouraged to ask questions.
3. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. Consent to Treatment Using Telemedicine and I have consented to treatment involving the use of electronic communications to enable my provider to share my individual patient medical information for diagnosis, therapy, follow-up, and/or education purposes with my other medical providers. I consent to forwarding my information to a third party as needed to receive telemedicine services,

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and I understand that existing confidentiality protections apply. I acknowledge that while telemedicine can be used to provide improved access to psychiatric care, there are potential risks and no results can be guaranteed or assured. These risks include, but are not limited to: technical problems with the information transmission; equipment failures that could result in lost information or delays in treatment. In the case of technical difficulties, I consent that my provider may contact me on my telephone number or email on file.

B) Patient Consent for Financial Communications and Agreement

I acknowledge, that as a courtesy, the practice will bill my insurance company for services provided to me. I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance. I understand there is a fee for returned checks for $35. Cash payments are due before each visit.

C) Good Faith Estimate

By law, health care providers are required to give patients **who don't have certain types of health care coverage or who are not using certain types of health care coverage** a "good faith estimate" of their bill for health care items and services before those items or services are provided.

The law provides as follows:

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.

If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

For questions or more information about your right to a Good Faith Estimate:

- visit www.cms.gov/nosurprises/consumers
- email FederalPPDRQuestions@cms.hhs.gov or
- call 1-800-985-3059.

Full Name: _____ **Phone No:** _____

Signature: _____ **Date:** _____