THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

CONSENT FOR TREATMENT

I authorize OSU Psychiatry LLC and its physician(s) to provide diagnostic and treatment services to me. I understand that any medical service provided by a provider is independent and separate from care provided by the hospital.

The Providers have my permission to release any information needed for completion of their claims for payment from third-party payors including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, government organizations and their representatives, and also to organizations that help pay my bill and agents hired to collect or obtain payment.

I permit the release of information concerning dates of treatment, condition, diagnosis and procedures to my personal physician, referring physician and/or referral facility for the purpose of follow up care. I am aware that this information will contain psychiatric treatment information, and may contain information regarding HIV, AIDS, or drug abuse.
____ Please initial to indicate approval

I acknowledge financial responsibility for all my Provider fees. I understand that the Providers will file my insurance claim for me or will provide me with sufficient information to file my own claims, if I so desire. I assign direct payment to Providers of all payments made under the terms and provisions of my insurance policy. I understand that I am responsible for and will pay unpaid amount due to services performed by Providers.

I agree that due to the nature of my relationship between Providers and me, if my Providers believe access to my medical records is inconsistent with my treatment plan based upon clear treatment reasons, access to the information in my medical record, other than my diagnosis, prognosis and a list of available services and personnel, may be withheld. If my Providers withhold this information, I understand that I have the right to have that decision reviewed by Provider's chief clinical officer.

By signing my name below, I certify that I have read, understood and agreed to the above.

________________________ __________________________________ ___________________________
Patient Witness Date

________________________ __________________________________ ____________________________
Authorized Agent Relationship to patient Date

REFUSAL TO RELEASE INFORMATION TO INSURERS
I do not authorize the release to my insurance company of information concerning my medical care and treatment to my insurance company. I understand that I am personally responsible for and will pay all charges for services performed by Providers.

_____________________________________ ______________________
Patient Date

Name: Medical Record #: DOB: