**Lakeview Medical & Psychiatric Healthcare LLC**

**1601 West Jackson Street Suite 104**

**Macomb, IL 61455**

**CLIENTS INFORMED CONSENT, AGREEMENT AND AUTHORIZATIONS**

INFORMED CONSENT FOR TREATMENT

I am aware that Lakeview Medical & Psychiatric HealthCare LLC and staff will conduct all or part of my care. I have been informed of the services offered and understand the risks and benefits inherent in the services provided by the Lakeview staff. I understand my participation in treatment may generate stress and/or emotional discomfort as I address issues identified in treatment. I understand that my treatment may be revised periodically with my prior knowledge of my progress or lack of progress. I recognize that the practice of mental health treatment is not an exact science, and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcome of any treatment. I hereby consent to the treatment provided by Lakeview Medical & Psychiatric HealthCare LLC as well as employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. (\_\_\_\_\_\_\_) initials

CLIENT AGREEMENT

I agree that during the time that I am an active client of Lakeview Medical & Psychiatric HealthCare LLC; I will cooperate as best I can to keep the company informed of my place of residence, employment status and my progress. I understand that my provider has office hours as posted and the office is opened Monday through Friday as listed in the “Hours of Operation” in the office. I will call **at LEAST 24 HOURS in advance to cancel appointments and agree to pay $25.00 for otherwise missed appointments. I agree to pay my account in FULL before scheduling further services.** I accept that my case may be terminated after two (2) otherwise missed appointments in six (6) months. If I decide to stop treatment at any time, I agree to inform my provider. I understand that in case of emergency my provider can be reached at any time; (309) 575-3222, by calling 911 or going to the nearest emergency room. (\_\_\_\_\_\_\_) initials

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize use and disclosure of my personal health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my care, or for conducting the healthcare operations. I authorize Lakeview Medical & Psychiatric HealthCare LLC to release any information required in the process of applications for financial coverage for services rendered. This authorization provides that we may release the minimal necessary amount of objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agent (\_\_\_\_\_\_\_) initials

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ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARNTEE/COLLECTION FEE

I authorize payment to be made directly to Lakeview Medical & Psychiatric HealthCare LLC for insurance benefits that are payable to me. I understand that I am financially responsible to Lakeview Medical & Psychiatric HealthCare LLC **AT THE TIME OF SERVICE** for covered or non-covered services including copays and deductibles; as defined by my insurer. I understand Lakeview Medical & Psychiatric Healthcare LLC accepts cash and credit cards, no personal checks are accepted. I understand that a monthly 1.5% interest charge will be applied to my unpaid account balance after 90 days. I understand that if my account becomes delinquent and requires collection, I am responsible an additional 30% of the balance on the account for the collection including any legal

 fees. (\_\_\_\_\_\_) initials

MEDICATION REFILLS

I understand Lakeview Medical and Psychiatric Healthcare LLC policy states medication refills can take up to 5 business days to process. It is my responsibility to contact my pharmacy when refills are needed. (\_\_\_\_\_\_) initials

PRIVACY POLICY

I have received a copy of the Clients Notification of Privacy Practices, clients Rights, and Responsibilities. The information was explained using language that I understand. I have been offered my rights with verbal explanation, including the right to see and copy my records, to limit disclosure of my health information, except to the extent Lakeview Medical & Psychiatric HealthCare LLC has already made with my prior consent. (\_\_\_\_\_\_) initials

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Client Signature Date

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Parent/Authorized Person Signature Date

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Witness Signature Date

Updated 08/31/18