Informed Consent to treatment

I have voluntarily chosen to receive treatment with Mind Body Institute of Chester County, or the office staff or contractors (Provider). In a good therapeutic relationship it is considered my right as well my duty to ask any questions and fully discuss the risks and benefits of any proposed treatment. It should also include the risks & benefits of any alternate treatment/or no treatment.
I have discussed the pertinent information with the provider.

Pt/REP Signature:_____ Date_____

Pt Name:_____

Acceptance of Financial Responsibility:

I take full responsibility of the financial liability for the proposed services provided. I understand that the time is reserved in advance. If I don't give at least 24- 48 hours notice to cancel, I may be charged $25-50 . I am responsible for co-pay, coinsurance, deductible, & non-covered services. There is a $5 charge for late payment of co pay. We charged $30 for any bounced bank check. I allow Dr. Irfan and his associates to bill my insurance company.

Pt/REP Signature:_____ Date_____

Pt Name:_____

Medical Records Release etc.

I understand that the confidentiality of my records is protected, and release of information will be only by my written consent. Exceptions to confidentiality are as follows: a) local and state law may require reports of cases of child/minor/elderly abuse or neglect; b) if there is danger to self or others. C) Court order.

I understand that all records pertaining to my treatment may be released to my insurance company for claim processing, utilization review purposes, quality management or grievance/appeal process etc.

Pt Signature:_____ Date_____

Pt. Name:_____

Guardian's Signature:_____ Date_____
Guardian's Name:_____