David Schatzkamer LMHC, PLLC

Patient Consent Form

Consent for Medical Treatment. I give consent to David Schatzkamer LMHC, PLLC, its staff, therapists and practitioners (the "Practice") to provide and perform such care, tests, procedures, and other services that the Practice deems necessary or beneficial for my health and well being.

Authorization of Payment of Insurance Benefits/Signature on File. I authorize payment to the Practice of all monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care and treatment. I hereby authorize the release of any/all information about me for the purposes of payment for services rendered to me.

Financial Agreement. I agree to pay all amounts for which I am financially responsible. I understand that, to the extent permitted by law, where insurance or other third party benefits are insufficient, I will be responsible for the payment of any balances due, including deductibles, copayments, coinsurance or other fees. I understand that if I have not provided the Practice with accurate and current information regarding my insurer or other benefit plan/third party payor which provides me with health care coverage, I will be personally responsible for the cost of all care rendered by the Practice. I understand that the Practice may require a consumer credit report in connection with the collection of an account. I authorize the Practice as well as its collection agency/attorney to obtain a consumer credit report. I agree to pay all bills when presented. Should the account be referred to an attorney for collection, I shall pay all reasonable attorney fees and collection expenses. I understand that there will be a charge for all returned checks

Authorization for Release of Information. I authorize the Practice to release my health information: (1) to a health care provider for my diagnosis, care or treatment or for that provider's payment or health care operation purposes; (2) to any person or entity which may be responsible for billing/collection of claims for medical services or products; (3) to any person or entity which is, or may be liable to, the Practice or me for all or part of the Practice' charges, including but not limited to, third party payors; (4) to any governments agency or other organization responsible for oversight of the Practice or a third party payor; (5) for the Practice' normal health care operations. I authorize the Practice to communicate with me through text or email, even if not encrypted, and to allow the individuals listed above to access such information through any medium including over the Internet.

Filming. I understand that photographs or other images of me may be recorded for the Practice's treatment and quality assurance purposes. To the extent that such images identify me, I understand that they shall receive the same confidentiality protections as my other health information.

Signature. I have carefully read and fully understand this informed consent form and have had all my questions answered.

_____	_____	_____
Signature of Patient	Print Name	Date
_____	_____	
Signature of Patient/legal Representative	Relationship to Patient	