SUNSTONE
PSYCHIATRIC

Authorization and Informed Consent for Treatment

I have reviewed, understand, and agree with the conditions and policies described in Sunstone Psychiatric, LLC Office and Practice Policies, Patient Rights & Responsibilities, HIPPA Data Use Agreement, and Credit Card Authorization.

I do hereby and voluntarily consent to treatment provided by Sunstone Psychiatric, LLC.

I understand that I have the right to terminate my participation in treatment at any time and Sunstone Psychiatric, LLC reserves the right to terminate treatment for reasons noted in Practice Policies and Patient Rights & Responsibilities.

Authorization for Release of Information and Assignment of Insurance Benefits

Sunstone Psychiatric, LLC and/or DrChrono have my permission to communicate with my insurance company to provide information necessary to obtain authorization for services, provision of services and coordination of care.

Sunstone Psychiatric, LLC and/or DrChrono have my permission to bill my insurance company and provide necessary information for the purposes of obtaining authorization for services, benefit information and payment as well as accept payment from that company on my behalf for all services relating to my care.

I understand that I am financially responsible for all charges not covered by my insurance and for any appointment that I fail to keep or cancel with less than 48 hours prior to that appointment time.

By signing this form, I consent to psychiatric evaluation/treatment by Sunstone Psychiatric, LLC, our use and disclosure of your Protected Health Information (PHI) to carry out treatment, payment activities, and healthcare operations. I also acknowledge receipt, understanding of and agreement to Sunstone Psychiatric, LLC's Office and Practice Policies, Patient Rights & Responsibilities, HIPPA Data Use Agreement, Credit Card Authorization as well as payment and fees. The duration of this consent is indefinite and continues until revoked in writing.