OLENTANGY PEDIATRICS, INC
MEDICAL TREATMENT CONSENT FORM

General Consent for Treatment

By signing below I am acknowledging that I am the patient or parent/legal guardian if a minor child. I voluntarily authorize and consent to medical care, treatments, diagnostic tests, and psychological services that the providers of Olentangy Pediatrics, Inc. and their designated associates or assistants believe are medically necessary.

I understand that by signing this form that I am giving permission to the doctors, nurses, physician assistants, and other healthcare providers in this medical office to provide treatment as long as a physician/patient relationship exists. I understand I have the right to revoke this authorization in writing at any time.

By signing, I confirm that I have legal ability to consent for treatment of services provided by Olentangy Pediatrics, Inc..

_____ _____

Patient Name DOB

_____ _____

Patient Signature or Parent/Legal Guardian if patient is under 18 Date

_____

Parent or Legal Guardian Name Printed, if patient is under 18

FINANCIAL POLICY FOR PSYCHOLOGY SERVICES AT OLENTANGY PEDIATRICS, INC

Our office maintains a billing relationship with many, but not all, health insurance companies. It is important for families to educate themselves about the mental health benefits of their health insurance policies. This includes finding out if you have a deductible, the amount of your co-payment/coinsurance, and whether pre-authorization is required. Coverage may NOT be available for specific diagnoses, or for particular services. Again please verify coverage directly with your insurance company, as it is ultimately your responsibility to know your health plans specific benefits and requirements including any plan limitations or exclusions.

If we are NOT contracted to bill your health insurance company, payment in full is due at the time of the appointment. Families using out-of-network benefits can request copies of fee slips so that you can submit the claim for possible reimbursement.

Fees for psychological services depend on the nature of the services and how much time will be required to complete them. Upon request we can provide you a verbal quote for services over the phone and a written quote prior to services being rendered.

NO SHOW/LATE CANCELLATION POLICY FOR PSYCHOLOGICAL SERVICES

Appointments that are not kept or that are not cancelled at least 24 hours in advance may be subject to a missed appointment fee of **$150.00**. This fee is not covered by any insurance company and will be billed to the guarantor.

AGREEMENT TO PAY FOR PSYCHOLOGICAL SERVICES

I hereby agree to financial responsibility for psychological services rendered to myself or member of my family by Olentangy Pediatrics. I understand that even though I may have health insurance benefits for some services, I am responsible for any deductibles, co-insurances, co-payments, or services not covered by my insurance. I hereby authorize Olentangy Pediatrics to release any and all information necessary to obtain payment from insurance companies for the services rendered. I authorize the use of this form on all of my insurance submissions. I authorize payment directly to Olentangy Pediatrics, Inc.

_____

Patient Name

_____ _____

Signature of Patient (Parent/Legal Guardian if Under 18) Date

Olentangy Pediatrics, Inc.

Anne D. Littleton, M.D.
Irene P. Koesters, M.D.
Mitchell R. Camp, M.D.
Eileen M. Maher, M.D.
Autumn M. O'Brien, M.D.
Claire S. Ackerman, Ph.D.
S. Randall Brown, M.D.
Emily T. Ferguson, M.D.
Heather K. Guthrie, Ph.D.

I, _____, hereby authorize _____
Print Parent/Legal Guardian Name — Doctor Name

to release/receive any and all information pertaining to the health, education, and psychological status of my son/daughter _____ to/from:
Child's Name

_____ Psychologist

_____ Psychiatrist

_____ Teacher

_____ Counselor

_____ Other

_____ Other

_____ Child's DOB

_____ Parent/Guardian Signature

_____ Date

4775 Knightsbridge Blvd., Columbus, Ohio 43214 • 614-442-5557 • Fax 614-442-1070

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TELEPSYCHOLOGY INFORMED CONSENT

As a client receiving psychological services through telepsychology methods, I understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email) and may not involve direct, face to face, communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means.

2. I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits.

3. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My psychologist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.

4. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means: a. In emergency situations b. Should service be disrupted c. For other communication

5. Other than receiving the link for the appointment through email, **I will not communicate otherwise with my provider through email. I understand that I may send messages through the patient portal or may call into the office.**

6. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

7. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services.

This document does not replace other agreements, contracts, or documentation of informed consent.

_____ Client Printed Name

_____Signature of Client or Legal Guardian

_____ Date

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