North Atlanta Psychiatric Services, Inc.
Joseph Berger, MD, R. Ph.

Authorizations and Consent to Treat

Client Name:_____

1. Authorization to Release Information to PCP

Communication between behavioral health providers and your primary care physician is important to ensure that you receive comprehensive and quality health care. I hereby authorize release of my protected health information related to my evaluation and treatment to my primary care physician (PCP). I understand this information may include diagnosis, treatment plan, progress and medication information if necessary. I understand that I may revoke this consent in writing at any time except to the extent that is has been relied upon.

_____ _____
Signature of Consumer/Legal Guardian/Legal Representative Date

2. Failed Appointments

I agree to notify Joseph Berger, MD at least twenty-four (24) hours prior to the beginning of my scheduled appointment if I decide to cancel/change. I understand I will be charged for an appointment not kept or canceled at least 24 hours prior to the beginning of my scheduled appointment.

_____ _____
Signature of Consumer/Legal Guardian/Legal Representative Date

3. Client Rights and Responsibilities
A Person Receiving Services is Entitled to:

1. Mental Health/Chemical Dependency services in accordance with standards of professional practice, appropriate to his/her needs and designed to give him/her a reasonable opportunity to improve his/her condition.
2. Humane care, protection from harm, and to be treated with dignity and respect.
3. The right to participate in the development and review of his/her treatment plan, including the known effects of receiving and not receiving such treatment, or alternative treatment, if any.
4. The right to receive treatment in the least restrictive settings
5. The right to review his/her own record in the presence of the primary therapist, unless the primary therapist's professional judgment deems this to be potentially detrimental to the person.
6. The right to confidential maintenance of all his/her identifying treatment information; no disclosure of such information without his/her written authorization, except in cases of medical emergency, by court order, or when otherwise dictated by law.
7. The right to register complaints and to have his/her complaints heard and action taken, if required, promptly
8. The right to waive any of his/her rights, if the waiver is given voluntarily, knowingly, and in a competent state of mind. The waiver may be withdrawn at any time.

_____ _____
Signature of Consumer/Legal Guardian/Legal Representative Date

North Atlanta Psychiatric Services, Inc.
Joseph Berger, MD, RPh

4. Consumer Consent for Use/Disclosure of Health Care Information

I understand that the consumer's health information is private and confidential. I understand that Joseph Berger works very hard to protect the consumer's privacy and preserve the confidentiality of the consumer's personal health information.

I understand that Joseph Berger may use and disclose the consumer's personal health information to help provide health care to the consumer, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. Examples would be if a consumer threatened to hurt someone or if child abuse is reported.

Joseph Berger has a detailed document called the "Notice of Privacy Practices", given to me in my orientation handbook. It contains more information about the policies and practices protecting the consumer's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Joseph Berger may update this "Notice of Privacy Practices". If I ask, he will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Joseph Berger to limit how the consumer's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Joseph Berger does not have to agree to my request. If Joseph Berger does agree to my request, I understand that Joseph Berger would follow the agreed limits. Requests must be made in writing and Joseph Berger will provide a form for this purpose by request at any office.

I may cancel this consent in writing at any time by doing one of the following:
. Signing and dating a form that Joseph Berger can give me called "Revocation of Consent for Use and Disclosure of Health Care Information"; or . Writing, signing, and dating a letter to Joseph Berger. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the consumer's personal health information for treatment, payment, and health care operations.

If I revoke this consent, Joseph Berger does not have to provide any further health care services to the consumer or may require that the consumer pay directly for any service rendered.

My signature below indicates that I have been given the chance to review a current copy of Joseph Berger's "Notice of Privacy Practices". My signatures means that I agree to allow Joseph Berger to use and disclose the consumer's personal health information to carry out treatment, payment, and health care operations.

_____ _____
Signature of Consumer/Legal Guardian/Legal Representative Date

I have read the preceding information and have been given information detailing policies and procedures of Joseph Berger's medical practice. I have been given the opportunity to ask questions and agree to abide by these policies. I authorize and request my behavioral healthcare professional to carry out psychological evaluations, psychiatric evaluations, treatment and/or diagnostic procedures that now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my behavioral healthcare professional can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that reactions will be worked on between my behavioral healthcare professional and me. With these understandings, I hereby authorize treatment for myself. I give permission for Joseph Berger to develop a treatment plan and provide treatment.

_____ _____
Signature of Consumer/Legal Guardian/Legal Representative Date