REQUEST TO TREAT: CONSENT FOR SERVICES

Patient Name: _____ **Patient DOB:** _____

Patient Location: _____

Patient Healthcare Decision Maker (*circle one*):
PATIENT LEGAL GUARDIAN POA OTHER

Service Requested: ☐ Primary Care ☐ Mental Health

- I request and consent to the above services delivered by LifeSource of NC, Inc. clinician designee(s). I understand that this includes routine primary care services, as well as psychiatric medication management and/ or psychotherapy services as determined by medical necessity.
- I have been informed of my rights, including the right to consent to or refuse treatment; I have received or been offered a copy of LifeSource's Notice of Privacy Practices, Client Rights', and Grievance policies, which provide information about how LifeSource uses and discloses Protected Health Information. I understand that some services may be provided via telehealth when or if necessary and appropriate. I have received or been offered a copy of LifeSource's Telehealth Policy.
- I authorize any entity with medical information about me to release said information to my insurance company or to the Centers for Medicare and Medicaid Services and its agents, if needed, to determine the benefits payable for requested services.
- I request that payment of authorized insurance benefits be made on my behalf to the LifeSource clinician designee for requested services. I understand that my insurance company may assign a portion of the bill as patient liability. I understand that my financially responsible party may be informed that I am receiving services for billing purposes unless I request otherwise.
- I authorize the release of information to my Attending Physician and/or facility for the purpose of coordination of care. I understand that my treating providers may use electronic communication to share my medical information as part of coordination of care. I understand that a copy of my medical records will be kept on file at the site where requested services are provided, and that the release/ disclosure of my protected health information is subject to all HIPAA guidelines. The duration of this consent is until the discontinuation of service by the provider or patient.

REQUIRED SIGNATURES: ***(If signing as Legal Guardian, proof of guardianship required)***

_____ _____ _____
Patient or Legal Guardian Signature | Patient or Legal Guardian Printed Name | Date

_____ _____ _____
Witness Signature *(If signature illegible)* | Witness Printed Name | Date

Or, in accordance with Medical Statutes:

_____ _____ _____
Responsible Party Signature | Responsible Party Printed Name | Date

Relationship to Patient (required): _____

OR, If Patient/ Responsible Party unable to physically sign d/t COVID restrictions, complete this section instead:

Verbal consent received from _____**Relationship to Patient**:_____

on (*date and time*)_____ **by staff member** (*name*) _____