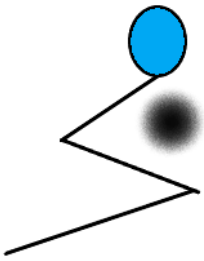

ZenBees Psychiatry and Wellness Services, LLC.
180 Thomas Johnson Drive, #100
Frederick, MD 21702
Phone: 410-693-7401
Fax: 534-429-4341
Email: Zb@zenbeespsychiatry.com

Patient Consent and Acknowledgement Form

Patient Name: _____
DOB: _____

Office Policy: I agree to provide a copy of my driver license and insurance card for eligibility verification and claim submission. I agree to that it is my responsibility to keep track of my appointment. I understand I missed my appointment or fail to cancel my appointment 48 hours in advance, I will be responsible for a no show/late cancellation fee of $120, which is not covered by insurance. I have read the facility/provider discharge policy and agreed to those terms. I understand that the facility/provider cannot guarantee the accuracy of copayment or coverage from my insurance plan. I am responsible for the non-covered services by my insurance. I also understand that the facility/provider will charge for time spent on any forms, reports, medication authorization or extensive phone call, family consultation or consultation with other provider/therapist/specialist. I acknowledge that a copy of the office policy is available on this company website for me to download or save. https://www.zenbeespsychiatry.com/client-info/.

Consent for treatment:
I hereby authorize the personnel and providers of this facility to render such care as they deem necessary and appropriate in their professional judgment. I understand that I have the right to make informed decisions regarding all care and treatment, and that I should ask the personnel of this facility to clarify any details of my care that I do not understand. This would include the right to refuse treatments that I do not want.

Assignment of Benefits
I hereby authorize this facility/provider to receive direct payment of any insurance, or other benefits payable to me for the services rendered.

Telehealth Patient Consent
I hereby have been informed of telehealth services policy and privacy. I acknowledge that telehealth sessions should be conducted confidentially. I will be a private space, without interruption, and without other people present. I consent to participate in telehealth appointments in connection with the services provided by Zenbees Psychiatry & Wellness Services, LLC.

Authorization to Release Information
I authorize the personnel and providers of this facility to release any medical information deemed necessary to the identified third-party payers and/or legitimate agents of the listed parties to determine benefits payable. This includes the identified providers as requested by me.

Guarantee of payment
I acknowledge financial responsibility of any health insurance deductible, co-insurance, or failure for any reason of any insurance carrier to pay the medical facility or practice's charge in full when service rendered. I am required to provide a referral if it is required by my insurance company. If a referral is not provided, I understand that I will be responsible for the total fee incurred. I also acknowledge that interest may be charged to unpaid balances over 30 days from the date of payment is due. In the events that the account is referred to collection, I agree to pay all reasonable collection and attorney fees required to collect any delinquent balance. I also agree to the recurring credit card payment, as provided by me, for the co-pays, coinsurance and deductible amount that are due at the time of service. If I chose to agree to a self-pay plan, I shall comply to the terms of agreement, financial responsibility and cancellation policy.

Patient's Certification, Authorization to Release Information for Medicare/Medicaid
I hereby certify that the information given by me applying for payment under TITLE XVIII (Medicare) and XIX (Medicaid) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim.

Patient rights and responsibilities
By signing below, I acknowledge that I have received information about Patient's Rights and Responsibilities. I also have received and review the HIPAA Notice of Privacy Practices. I consent to use and disclose my health protected information about my treatment, payment, and healthcare related operations. I understand that this facility/provider reserve the right to change the terms described. I am aware that the Notice of Privacy is available on this company's website, and I can also request a copy.

Notice of privacy of practices
My initial acknowledge that I received ZenBees Psychiatry and Wellness Services, LLC. Office policies, notice of privacy and practice. I certify that I have read, understand, and agree to the terms and conditions of this facility/policies and that I am authorized as the patient or the patient's representative to sign this document and be bound by its terms.

_____	_____	_____
Patient's Signature	Date	Time

If the patient is under 18 years old or unable to sign:

Authorized Person's Name: _____

Relationship to patient _____

Authorized Person's Signature _____ Date _____