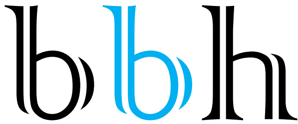

Balance Behavioral Health PLLC
6504 Woodlake Village Circle
Midlothian, VA 23112
ph: 804-823-5475
fax: 804-818-3644

PSYCHIATRIC SERVICES AGREEMENTS

Informed Consent

I have read and understood the **Patient Information and Professional Service Agreement**. I have had an opportunity to ask questions, and I agree to enter treatment with Balance Behavioral Health, PLLC. I have also had the opportunity to review and agree to the current **Fee Agreement and Good Faith Estimate** as required by the No Surprises Act for out-of-network services, which is included in the above packet. By signing this form, you agree to pay the full fee at the time of your treatment, unless otherwise arranged or if your clinician is in-network with your insurance. If in-network any co-pays or co-insurance are due at time of service.

It is federal requirement that each patient sign this form annually to begin/continue treatment.

Signature:_______________________________________ **Date:**_______________________________

Printed Name of Person signing form and relationship to the patient if signing on their behalf:

Name:_______________________________________ **Relationship:**______________________________

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. I have read, understood and agree to the items contained in the **HIPAA Notice of Privacy Practices** (a copy of which is available upon request).

Signature:_______________________________________ **Date:**_______________________________

Printed Name of Person signing form and relationship to the patient if signing on their behalf:

Name:_______________________________________ **Relationship:**______________________________

I have read, understood, and agree to the items contained in the **Telehealth Informed Consent Agreement** (a copy of which is available upon request).

Signature:_______________________________________ **Date:**_______________________________

Printed Name of Person signing form and relationship to the patient if signing on their behalf:

Name:_______________________________________ **Relationship:**______________________________