Consent For Treatment

Thank you for choosing **Autism Allies, LLC (AA, LLC)**, where we care for autistic children, adolescents and adults. We consider families to be an essential participant in yours and your child's care and wish to support and respect your needs while your son, daughter or yourself is here. We want you to understand your rights and responsibilities as families and patients at AA, LLC. Your signature on this form provides consent for treatment, payment, and acknowledges AA, LLC office policies and receipt of other general information. If you have questions, please contact us 303-920-5161.

Consent for Treatment: I consent to and authorize the attending physician, physician's assistant, referring providers and others of the healthcare team, including providers in training, and students in other disciplines - to perform healthcare examinations, treatment, diagnostic testing, transfers and transportation as deemed medically necessary in their professional judgment.

Consent for Medical Photographs, Recording or Filming: I hereby grant permission for taking of photographs – for identification purposes, recording or filming for medical and training purposes as requested by my care-providers.

Research: I hereby grant permission to use my medical chart in a de-identified fashion to study the efficacy and safety of interventions used in my care. No information identifying me will be released without my express consent.

Expert Witness Rates/Fees: Our practice does NOT provide expert testimony. If AA, LLC is compelled to testify in this capacity for you, you agree to pay AA, LLC $1,000/hour with a two hour minimum deposit.

Assignment of Benefits and Release of Information

- I agree to be responsible for my charges of AA, LLC and of providers rendering services not covered or paid by insurance or other third party payers – except as prohibited by state or federal law.
- I authorize AA, LLC to file any claims for payment of any portion of the patient bills and assign all rights and benefits payable for provider services to the provider or organization furnishing the services.
- I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses, delinquent charges and interest in the event AA, LLC has to take action to collect same because of my failure to pay in full all incurred charges within 60 days after receipt of the bill.
- The term of this consent will be until final payments are made for any and all services.
- If and when there are changes to my insurance plans, I will notify AA, LLC staff immediately.

Cancellation and Late Policy

___ I agree that:

- If I do not show up, or cancel my appointment with less than 24 hours notice that I will be charged $115.00 **automatically** through the credit card I have on file.
- I will need to keep a credit card on file so that in case I do not show up, or cancel my appointment with less than 24 hours notice I can be charged automatically. I understand that my card will be kept on file for this reason only.
- If I do not show up for an appointment or late cancel 2 or more times that I will be released from AA, LLC care.
- If I arrive more than 10 minutes late for an appointment that it will be rescheduled and considered a late cancel.

Billing Policy

___ I agree that If I have an outstanding balance, I will be required to pay this balance in full before scheduling any future appointments and will help AA, LLC to resolve any issues with my balance or insurance company.

General Information

___ I understand:

- AA, LLC may prescribe medication and require that the patient takes the medication as recommended.
- The first appointment is approximately one hour. All subsequent "follow-up" visits are intended to provide a brief checkup on the patient's status and to adjust or refill prescriptions. I will review the number of pills the patient has left before coming to the office.
- AA, LLC will give me a list of recommended therapists if they feel it is appropriate, which they expect the patient to see on a regular basis.

Disability

___ I understand: Our practice does NOT evaluate patients for disability. There are doctors in the community specially trained to evaluate disability. We do not have this training and cannot, in good conscience, evaluate people for benefits as we are not trained to do so.

Notice of Privacy Practices

___ I acknowledge the receipt of AA, LLC's "Notice of Privacy Practices" brochure.

Video Conferencing

___ I acknowledge that if my child is not able to come in due to uncontrolled behavior, the patient's appointment will be video conferenced via a HIPAA compliant video chat. I acknowledge that this video conference must be scheduled ahead of time.

_____	_____	_____
Print Patient's Name	Guardian's Printed Name/Relationship (if applicable)	Date
_____	_____	
Patient Address	City/State/Zip	
_____	_____	_____
Emergency Contact Name	Emergency Contact Phone	Patient Signature (Guardian Signature if under 18)

_____

AA, LLC Staff Witness Signature and Date