William B. Orr Consulting PA; The Orr Memory Clinic Consent

Patient's Medicare Authorization (Patients with Medicare):

I hereby request that payment of authorized Medicare benefits be made on my behalf to William B. Orr Consulting PA for any services furnished to me by a provider at The Orr Clinic. I authorize any holder of medical or hospital information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

SIGNED_____DATE_____

Agreement for Collaborative Services with Your Primary Care Provider:

_____ **I agree** to allow communication between my primary care provider(s) and mental health provider(s) at The Orr Clinic in order to ensure regular communication and coordinated services for my care.

_____ **I agree** to allow communication between the Assisted Living or Memory Care facility to coordinate my care.

SIGNED_____DATE_____

Agreement on Services Which May Not Be Covered by Insurance:

My provider at The Orr Clinic will bill my insurance company for me, and I may subsequently receive notice that all or part of these charges is considered by them to be an "uncovered expense." Examples include deductibles, copayments, coinsurance, etc.

-I understand and acknowledge, in advance, that I am seeking services at The Orr Clinic knowing that they may not be covered.

-I agree to cover the full cost, less insurance payments.

-I understand that it is my responsibility to contact my insurer, and to understand my coverage, including what the insurer may pay and what will be my cost.

SIGNED_____DATE_____

I understand that I am expected to attend all scheduled appointments or cancel them at least 24 hours prior to my appointment. If I do not do so, I may be charged a ***$50.00 late-cancel or no-show fee*** *and that my insurance will not pay this fee.*

SIGNED_____DATE_____