Patient Acknowledgment Form for Stepping Stones Psychiatric Services, PLLC

Practice Information and Agreement

_____ **(initial)** I have read and understand the Practice Information and Agreement. I agree to abide by its terms while I am receiving services at Stepping Stones Psychiatric Services, PLLC

Notice of Privacy Practices

_____ **(initial)** By initialing here and signing below, patient hereby acknowledges that he/she was offered a copy of the notice of privacy practices and can obtain a copy at www.steppingstones.care

Insurance and Payment

_____**(initial)** I understand that Stepping Stones Psychiatric Services, PLLC does not participate in any insurance plans and has opted out of Medicare. If I am covered under Medicare, I agree to not submitting any bills related to my care at Stepping Stones Psychiatric Services, PLLC for reimbursement to Medicare. If I have other insurance, I understand that I will be provided an invoice suitable for submission to my insurance for any Out of Network benefits I may have under my medical plan. I understand that payment for appointments are due, in full, at the time of each appointment.

Consent for Treatment

_____ **(initial)** By initialing here and signing below, patient hereby gives consent for treatment at Stepping Stones Psychiatric Services, PLLC.

Consent for Medication

_____ **(initial)** By initialing here and signing below, patient hereby acknowledges that he/she has read and understands the **Consent for Medication Agreement** outlined in the **Practice Information and Agreement**

_____

Patient Signature Date

_____

Printed Name of Patient

If you are signing on behalf of a patient, please indicate your relationship to the patient or capacity to serve as a patient's representative.

_____

Signature of Parent/Guardian or Representative Date

_____

Relationship to Patient