Psychiatric Specialists of Texas (PSOT)
5440 Old Brownsville Road
Corpus Christi, TX, 78417-9765
Ph 361-452-1151 | Fax 361-452-1517
https://psychspecialistsoftx.com/

Psychiatric Services of South Texas
Non-Custodial Parent Consent and Assignment of Benefits

Patient's Name: ____

Introduction: Psychiatric Specialists of Texas (PSOT) is a professional association that provides psychiatric services primarily to children and adolescents. Each patient's treatment will be individualized to his or her needs.

The professionals who are members of the team working with PSOT and who may serve the patient are physician assistants and nurse practitioners. A summary of qualifications of those individuals will be provided upon request. Any questions or concerns regarding professional services provided under PSOT may be discussed with any member of our professional team.

Fees: All fees are billed to the appropriate insurance provider shortly after services are provided. Fees cover evaluations, assessments, individual therapy, and family therapy as needed. Your insurance provider will send a statement, an Explanation of Benefits, of all of our services.

Confidentiality: Information about the resident is kept confidential in accordance with our privacy policy and requirements by the Health Insurance Portability and Accountability Act (HIPAA). Medical, legal, billing and ethical requirements specify certain conditions when it is necessary to share information about the patient with other professionals. The patient's insurance provider sometimes requests clinical information to support payment. Insurance companies are responsible for keeping this information confidential just as we are.

Consent to Photograph: I hereby authorize the office of PSOT to photograph the patient for identification purposes and for quality assurance purposes.

Assignment of Benefits: My right to payment for all procedures and services including major medical benefits are hereby assigned to PSOT. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance, and any other health plans. In the event my insurance carrier does not accept assignment of benefits or, if payment is made directly to my representative or me, I will endorse such payments to PSOT. I understand that I am responsible for any charge not reimbursed by Medicare or other insurance coverage that is in effect. I authorize Medicare or any other insurance carrier to release my personal data and any information regarding my coverage to PSOT. I also authorize agents of any hospital, nursing home, long-term care facility or previous psychiatrists or psychologists to furnish PSOT copies of any records of my medical history, services, and/or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state, or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of audits and quality assurance reviews within PSOT

I have read this document and understand the information contained in it. I understand that this informed consent and assignment of benefits will remain in effect unless revoked by me in writing.

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Non-Custodial Parent notified and/or signed

Name______________________________ Signature_______________________________ Date: _________