

STONE CREEK PSYCHIATRY
7945 Stone Creek Drive, Suite 130
Chanhassen, MN 55317
952-241-4050 (phone)
952-241-4049 (fax)

Treatment Agreement

Client Rights and Responsibilities

- I affirm that I have read and signed the Patient Rights and Responsibilities document and am aware that I may request a copy at any time, or view it at www.stonecreekpsychiatry.com.
- I affirm that I have been offered a copy of Stone Creek Psychiatry's Notice of Privacy Practices and am aware that I may request a copy at any time or view it at www.stonecreekpsychiatry.com.

Treatment Authorization

- I request Stone Creek Psychiatry to plan and provide treatment to me (or my minor child) with my participation. I understand that I may withdraw this consent and terminate treatment at any time, for any reason.
- I agree to have Stone Creek Psychiatry call me to confirm appointments.
- I authorize Stone Creek Psychiatry to leave a phone message regarding my appointments.

Payment Responsibility

- I authorize Stone Creek Psychiatry's billing service, MBBilling Services to process my claims and receive payment from my third party payer.
- I agree to pay all co-payments or co-insurance required by my health plan.
- If services I receive from Stone Creek Psychiatry are not covered by a third party payer, subject to the provisions of my third party payer contract, I agree to pay for these services myself. If balances extend beyond 120 days I understand a finance charge may be applied. If balances of services continue to be unpaid I understand that balances due may be sent to a collection service and are also grounds for being referred to another clinic.
- I agree to give Stone Creek Psychiatry 24 hour advance notice of any appointment cancellation. I understand that if I do not give this notice, I may be charged a fee. I am aware that insurance companies will not cover this cost.

Patient's Signature (or parent/legal guardian of minor)

Date: _____