THE MARCANN GROUP

3815 E Bell Rd. Suite 1500
Phoenix, AZ 85032
13925 W Meeker Blvd. Building B Suite 18A
Sun City West, AZ 85375
P: 602-824-9309 F: 602-916-1086
www.marcannmentalhealth.com

Today's Date: _____

Community Name: _____ Choose One: IL AL MC

Patient's Name: (*Last*) _____(*First*) _____(*MI*) _____

Date of Birth: _____ Social Security No: _____-_____-_____

Sex: Male / Female Marital Status: S / M / D / W Preferred language: _____

Street Address: _____ Apt No: _____

City/State/Zip: _____ Phone No: _____

ALT Phone No: _____ Email: _____

Preferred Pharmacy: Cross Street/Ph/Fax: _____

☐ **I DO NOT HAVE** an Active Medical Power of Attorney (MPOA), designated family member or requested care giver that oversees all consent to rendering medical decisions or acting on my behalf. I am solely responsible for making all medical decisions for myself.

☐ **I DO HAVE** an Active Medical Power of Attorney (MPOA) making all my medical decisions on my behalf: **The Marcann Group is required to contact the MPOA prior to any or all treatments or evaluations**

MPOA Name: _____ Phone No: _____
Address: _____ Email: _____

Emergency Contact: _____ Phone No: _____
Address: _____Relationship to Patient: _____

Financial Responsible Party: _____ Check Here if same as patient ○
Address: _____ Email:_____

Primary Insurance: _____Relationship to Patient:_____
Subscriber Name: _____SS#: _____ DOB: _____
ID Number: _____ Group ID: _____ Effective Date: _____

Secondary Insurance: _____Relationship to Patient:_____
Subscriber Name:_____ SS#: _____ DOB: _____
ID Number: _____ Group ID: _____Effective Date: _____

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Consent of Services

This consent is required by the Health Insurance Portability and Accountability act of 1996 to inform you or your privacy rights regarding your health care information.

Consent Related to Privacy Notice

_____ I have had the chance to review the practice privacy notice as part of this agreement process. I understand that the terms of the privacy notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information has been disclosed. I also have the right to restrict how the information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent for Care

_____ I with my signature authorize The Marcann Group, and any employee working under the direction health care provider to provide medical care for me. This medical care may include services rendered by the provider and other clinical staff including Registered Nurses, Medical Technicians and Case Managers, supplies related to my health care and may include, but not limited to mental status/ function of the body. This consent includes contact and discussion with other health care professionals for care and treatment. I acknowledge that The Marcann Group may and I/my POA may terminate services at any time for any reason with verbal and or written notice, and that termination would be effective immediately upon receipt of said notice.

Consent to release medical records

_____ I authorize The Marcann Group to furnish information to the identified insurance carrier(s) for any and all payment activities. I authorize this practice to release all medical records necessary for my treatment. I may revoke this authorization at any time by sending a written notification to The Marcann Group. I understand that any releases which were not made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

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Consent to release medical information to primary care physician and other clinicians

_____ I Authorize Communication between behavioral health providers and my primary care physicians and any other clinician that is important to help ensure that I receive comprehensive and quality health care. This information may include diagnosis, treatment plan, progress, and medication if necessary. This form is valid as long as I am a patient with The Marcann Group and am aware that I may revoke it at any time.

Medication Consent

_____ I have discussed the following information with my behavioral health medical practitioner for each medication listed below:

- The diagnosis and target symptoms for the medication recommended.
- The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment;
- The possible risks and side effects; including risk of medications to pregnant women and women who are breast feeding;
- The possible alternatives and complementary treatments;
- The possible results of not taking the recommended medications;
- The possibility that the medication dose and/or frequency may need to be adjusted over time, in consultation with the behavioral health medical practitioner;
- right to actively participate in treatment by discussing medication concerns or questions with the behavioral health medical practitioner;
- right to withdraw voluntary consent for medication at any time (unless the use of medications in treatment is required in a Court Order or in a Special Treatment Plan);

_____ I acknowledge that the above topics were covered entirely; I have consented to and accept the risks of treatment with the medication(s). I also understand that I have the right to refuse this/these medication(s) and that it/they cannot be administered without my consent. I may seek further information at any time that I wish, and I may withdraw my consent to treatment with the above medication(s) at any time by stating my intention to my prescriber. I certify with my signature that I have legal authority to sign this consent, and that the relationship listed is valid and legal.

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Authorization to Release Medical Information to the Marcann Group

This request and authorization applies to:

_____ Any and all information related to health care, including, but not limited to lab results, consultations, MRI's, CT scans, diagnosis and/or medication changes.

_____ To discuss current health status, including changes in medications, diagnosis, test results or consultations with The Marcann Group during any hospital stay including psychiatric care if applicable.

_____ This form is valid as long as I am a patient with The Marcann Group or revoke my consent as stated above. I have read and understand the above information and give my consent.

Primary Care Provider Name/Company: _____

Phone Number: _____ **Fax Number:** _____

Patient Name: _____

POA Name: _____

Patient/POA Signature: _____ Signature Date: _____