Riverview Psychiatry, LLC
Marie Beasley, DO
www.riverviewpsychiatry.com
Phone: 423-443-2120
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Consent to Treatment

Name of Patient: _____

Name of Parent/Guardian if Pt Under 18: _____

Email for Patient vs Parent/Guardian if Pt Under 18: _____

Telephone: _____

Address: _____

In applying for services with Dr. Beasley, I understand that I may be administered diagnostic and treatment procedures as may be determined by Dr. Beasley and as approved by myself, the parent or guardian.

Medical and other records may be maintained by Dr. Beasley for assessment and treatment. These records are confidential and are for the use of Dr. Beasley only.

I have read and understand the statements regarding HIPAA and patient's rights.

I understand that medical doctors are licensed and regulated by the Medical Board of Tennessee, https://www.tn.gov/health/article/ME-licensure .

Dr. Beasley will attempt to safeguard the patients in her care but will not be responsible for any accidental injuries and assumes no liability for injuries occurring without any fault or negligence.

Dr. Beasley accepts a patient into treatment in an effort to determine whether he or she can benefit from the services available. If in the opinion of Dr. Beasley the patient is not able to benefit, withdrawal will be recommended and other plans discussed.

I understand that while Dr. Beasley is available by phone and through the Practice Fusion patient portal for routine questions, she reserves 24 hours for responding to requests. Emergencies must be directed to the nearest emergency room or through dialing 911. After hours calls will be answered the following business day.

I understand that while Dr. Beasley will provide information required to obtain insurance company reimbursement, she will not bill insurance companies directly, not will she negotiate a settlement on disputed charges. I understand that I am fully and personally responsible for payment of Dr. Beasley's charges at time of services rendered. Failure to comply with this policy may result in postponement of future visits. Furthermore, if the amount due is not paid in full, I agree to bear all collection costs, court costs and legal fees.

I understand that I must allow 24 hours for processing of refill requests and that it is my responsibility to request refills in a timely manner. Additionally, refill requests for controlled substances will only be completed during normal business hours.

I understand that because of the highly specialized nature of her practice, Dr. Beasley does not participate in any managed care programs such as health maintenance organizations, preferred provider plans, worker's compensation cases or victims witness cases. Dr. Beasley is not a Medicare provider.

I understand that Dr. Beasley requests PAYMENT AT TIME OF VISIT BY CASH/CHECK/CREDIT CARD.

I understand that IF FOR ANY REASON AN APPOINTMENT NEEDS TO BE CHANGED OR CANCELLED BY THE PATIENT, 24 HOURS NOTIFICATION BY TELEPHONE OR PATIENT PORTAL MESSAGE WILL BE GIVEN TO THE DOCTOR. Failure to properly notify the physician will result in charges at the usual rate for that appointment. Exceptions will be made for legitimate emergencies as per physician discretion. I am in complete agreement that remembering upcoming appointments as set forth by Dr. Beasley is my sole responsibility, and that Dr. Beasley is not obligated to send reminder emails/phone calls prior to upcoming appointments. If you miss a scheduled appointment, you will be charge the full fee for the scheduled visit and payment is expected at the time of the next scheduled appointment.

I understand that Dr. Beasley may charge (at her discretion, which will be defined depending on the nature of the situation) for telephone consultations and for all other uses of her time on my behalf, at the hourly rate as defined for typical office visits. This could include attending school meetings either remotely or in person, collaboration of care with other providers, extensive phone conversations, etc.

I have read and understand the above mentioned policies and guidelines and will abide by ALL OF THESE POLICIES for services.

Date_____

Signature of Patient/Parent/Guardian _____