Amy Huberman, MD
1501 Sulgrave Avenue, Suite 202
Baltimore, MD 21209
443-823-0675

INFORMATION AND CONSENT FORM

CONSENT FOR RELEASE OF INFORMATION TO INSURANCE PLAN AND ASSIGNMENT OF BENEFITS:

________I give consent to Amy Huberman, M.D., to release medical information to my insurance company in writing (i.e. treatment plans) or verbally (i.e. requesting benefit/authorization information by phone). I understand that this consent may be revoked by me at any time in writing. I understand that nothing herein relieves me of the obligation to pay for medical services provided. If my insurance company limits visits, I accept responsibility for monitoring the number of allowed sessions used. I agree to pay for all non-covered services, including late cancellations/missed appointments, telephone appointments, services provided after benefit exhaustion, and services determined not to be necessary by my insurance carrier.

________I do not give consent to Amy Huberman, M.D., to apply for benefits or to release medical information to my insurance company. I accept responsibility for payment of all medical services provided, including telephone appointments, late cancellations, and missed sessions. I understand that my benefits may be reduced or absent because no information will be released to my insurance carrier.

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT:

________I give consent to Amy Huberman, M.D., to release health information by mail, phone, or fax to staff at my pharmacy for purposes of prescribing medication or clarifying medication issues. If my health plan requires pharmacy benefit management (PBM), I give consent to Amy Huberman, M.D., to release information to the PBM for the purpose of prescribing medication or clarifying medication issues.

________I give consent to Amy Huberman, M.D., to release health information by mail, phone, or fax to staff at laboratories for the purpose of providing laboratory services.

________I give consent to Amy Huberman, M.D., to release health information by mail, phone, or fax to my health care providers as described in the *Notice of Privacy Practices*, although specific authorization with verbal and written permission is preferred.

CONSENT FOR RELEASE OF INFORMATION FOR HEALTHCARE OPERATIONS:

________I give consent to Amy Huberman, M.D., to share necessary health information with staff she may hire to assist with billing, scheduling, or other office operations.

CONSENT FOR RELEASE OF INFORMATION FOR APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, OR HEALTH-RELATED PRODUCTS OR SERVICES:

________I give consent to Amy Huberman, M.D., to contact me by phone or by mail if in the future she offers appointment reminders.

________I give consent to Amy Huberman, M.D., to tell me in person about any non-FDA-approved treatments she believes may be of benefit to me.

POLICY FOR RELEASE OF INFORMATION IN SPECIAL SITUATIONS:

________I understand that Amy Huberman, M.D., may disclose health information about me in the event of a serious threat to the health and safety of myself or others, in the event of suspected child abuse or neglect, or in other situations detailed in the *Notice of Privacy Practices.*

POLICY REGARDING LATE CANCELLATIONS/MISSED APPOINTMENTS:

________I understand and accept that if I miss a scheduled appointment or if I cancel an appointment with less than one full business day's notice, I am responsible for the full fee for that appointment. I understand that insurance companies do not pay fees for missed appointments or late cancellations. I understand that this policy applies to illness, injuries, work problems, child care problems, and other last minute obligations. The only exception is a regional weather emergency.

POLICY REGARDING E-MAIL CORRESPONDENCE

________I understand that e-mail is not secure, and that if I choose to communicate with Dr. Huberman by e-mail my information could potentially be accessed by others. I understand also that Dr. Huberman does not check her e-mail regularly, so she requests that e-mail be used only as a means of communicating about non-urgent matters, such as scheduling of appointments. All important clinical information should be conveyed to her in person or by phone.

EMERGENCY CONTACT POLICY

________I understand that if I have a psychiatric emergency, I should contact Dr. Huberman, but if I am unable to reach her, I should call 911 or go to the nearest emergency room.

I have received a copy of Dr. Huberman's *Notice of Privacy Practices.*

Signature: ________________________________ Date: ____________________