HYGGE
psychiatry

Patient Consents and Agreement to Patient Responsibilities

1. **Consent for Healthcare Services**
   I voluntarily consent to healthcare evaluations, treatments, and related services, including non-invasive testing, provided by Hygge Psychiatry, and authorize Hygge Psychiatry to provide services it deems necessary and appropriate. I understand that additional consent may be required for certain treatments.I acknowledge that there is no guarantee of diagnosis, treatment, or prescription, and that in-person evaluation may be required. I understand that medicine, therapy, and counseling are not exact sciences and may involve risks, including injury or death. No guarantees or promises have been made regarding the outcomes of any evaluation, treatment, or service.I understand that I have the right to consent to or refuse any proposed treatment and to discuss such treatment with my provider. I further understand that I may withdraw this consent at any time, and that withdrawal of consent may result in termination of my relationship with Hygge Psychiatry.

2. **Information Practices**
   I authorize Hygge Psychiatry to utilize confidential health information contained in my medical record as necessary for insurance claims, payments, medical management, prior authorizations, or quality review activities. I authorize the release of such confidential information to other healthcare providers or facilities involved in my care, including for communicating with them to coordinate my care. I authorize the release of such confidential information to my insurance company or other health coverage plan as necessary for claims, payments, medical management and quality review activities conducted. Hygge Psychiatry's Notice of Privacy Practices provides more information regarding the use and disclosure of your health information.

3. **Notifications**
   I authorize Hygge Psychiatry, as a courtesy, to contact me and leave messages by voicemail, with household members, or via email, text, or similar technology regarding appointments, cancellations, billing, or related matters. I understand that such notifications are not guaranteed and that I am responsible for managing my appointments. I also consent to receive communications by mail, email, text, or other means related to my care and treatment, including information about Hygge Psychiatry's services, products, and recommendations for alternative treatments, providers, or settings of care.

4. **Financial Agreement and Assignment of Insurance Benefits**

In consideration of services rendered or to be rendered by Hygge Psychiatry, I hereby irrevocably assign to Hygge Psychiatry all medical insurance benefits to which I am entitled. I authorize and direct all insurance carriers, including Medicare, Medicaid, private insurers, and any other health plans, to remit payment directly to Hygge Psychiatry for services provided to me and/or my dependents. I agree that if I am covered by multiple insurance products, I am responsible for coordinations of benefits.

I understand and agree that I am personally and fully responsible for all charges not covered by insurance, including but not limited to copayments, coinsurance, deductibles, missed appointment fees, administrative charges, and other fees incurred in connection with services provided by Hygge Psychiatry, except as prohibited by applicable law or by contractual agreement between Hygge Psychiatry and my insurer. Failure to pay such charges may result in collection actions, and I agree, to the extent permitted by law, to pay all costs of collection, including attorney's fees, expenses, and interest.

I further understand that failure to timely pay outstanding balances, placement of my account in collections, or initiation of collection procedures may result in the inability to schedule future appointments and/or termination of my professional relationship with Hygge Psychiatry providers.

All applicable copayments, coinsurance, and deductibles are due at the time of service. For telehealth services, payment is due prior to the appointment.

Patients with outstanding balances may be required to pay in full or establish a payment plan. Failure to make reasonable efforts to resolve outstanding balances may result in rescheduling or cancellation of future appointments.

A fee of $50 will be charged for missed appointments or cancellations made with less than 24 hours' notice, except in extenuating circumstances. Two or more missed or late-canceled appointments may result in termination of services.

Declined credit card payments are subject to a $15 service charge.

Returned checks are subject to a $30 service charge and may result in revocation of the privilege to pay by check.

Hygge Psychiatry may charge fees for the completion of paperwork, particularly when such work requires provider time outside of a scheduled appointment, except where limited or prohibited by law. The fee for completion of a simple document (1–3 pages) is $40 per document. More complex documents may be billed at $100 per hour.

All services related to court or legal proceedings, including subpoenas, attorney-requested documentation, forensic work, and testimony (including testimony requested by another party), are not reimbursable by insurance and will be billed at $400 per hour. Such fees are the responsibility of the patient, or, at Hygge Psychiatry's discretion, the requesting or subpoenaing party.

Hygge Psychiatry may also charge fees for telephone calls outside of scheduled appointments that exceed five (5) minutes. Telephone fees, which are not reimbursable by insurance, are $40 for calls lasting 5–10 minutes, with an additional $40 for each additional ten (10) minutes.

All fees are due in advance, unless prohibited by law.

5. **Waiver of Responsibility for Personal Valuables**
   I understand and agree that Hygge Psychiatry is not responsible for the loss or damage to my personal property.

6. **Electronic Recordings**
   I understand and agree that to ensure confidentiality and privacy, electronic recording by anyone not duly authorized by Hygge Psychiatry is strictly prohibited, including on Hygge Psychiatry's premises and at any remote/ telehealth sessions.

7. **Emergencies and Non-Emergency Phone Calls**
   For serious, or life threatening emergencies, I agree to call 911 or go to my nearest emergency room. I understand that Hygge Psychiatry does not have a provider on call and does not answer telephone calls outside of normal business hours. I understand and agree that if I contact Hygge Psychiatry with non-emergency concerns or questions, it may take up to 48 hours to receive a call back.

8. **Medication Refills**
   Hygge Psychiatry will not process refill requests sent directly from pharmacies.
   Patients are required to contact our office directly for all medication refill requests, preferably through the patient portal (Follow My Health). This allows us to ensure regular follow-up and appropriate monitoring of symptoms and treatment progress. Please allow 7 days for all refill requests to ensure that you will not run out of medication.
   Patients prescribed controlled substances are required to have follow-up visits with their prescriber at least every three months. At least one visit per year must be conducted in person; additional visits may be completed via telehealth if preferred. Refill requests cannot be processed if the three-month visit requirement has not been met.

9. **Insurance Requirements**
   I agree that I am responsible for obtaining any required authorizations, precertifications, or referrals for services related to my treatment, except where prohibited by my insurance or managed care plan. I further understand that it is my responsibility to verify whether Hygge Psychiatry providers are in-network with my insurance carrier.

10. Telehealth Consent Agreement

Telehealth involves the use of electronic communications to provide healthcare services when the patient and provider are in different locations. I understand that family members, caregivers, legal representatives, or guardians may participate in telehealth services, and I authorize the sharing of my personal and health information with such individuals for purposes of diagnosis, treatment, follow-up, and education.

Telehealth services require the electronic transmission of health information, which may include medical records, assessments, reports, images, audio, video, text messages, biometric data, and other digital information. I understand that the same laws protecting the privacy and confidentiality of health information apply to telehealth services. My protected health information may be used and disclosed without additional consent for treatment, education, billing, and healthcare operations. I further consent to Hygge Psychiatry obtaining, using, storing, and sharing my information, including my image, with necessary third parties as required to provide telehealth services.

I acknowledge that telehealth involves inherent risks related to internet-based communication, including potential security breaches or technical failures. Hygge Psychiatry will use reasonable administrative, technical, and physical safeguards to protect the confidentiality and integrity of my information. I understand that individuals not directly involved in my care may have limited access to my information for purposes of operating or maintaining telehealth technology and will be subject to applicable privacy and security requirements.

I understand that telehealth services may be disrupted or unavailable due to technical or connectivity issues and hereby release and hold harmless Hygge Psychiatry and its providers from liability arising from loss of data or information caused by such technical failures.

I understand that I will receive information regarding the risks, benefits, alternatives, and limitations of tests, treatments, or procedures provided via telehealth. I have the right to refuse or withdraw consent to telehealth at any time, without affecting my right to future care or benefits.

No telehealth session will be recorded without my express consent. Telehealth visits will be billed in the same manner as in-person visits, and applicable copayments are due prior to the appointment.

I acknowledge that I have had the opportunity to ask questions regarding telehealth, that my questions have been answered to my satisfaction, and that I voluntarily consent to the use of telehealth services under the terms described above.

11. HIPAA Notice of Privacy Practices

A notice of our privacy practices and how your health information may be used and disclosed is available in paper format at the front desk, or may be accessed on our website. I acknowledge that I have received, or have been provided the opportunity to receive, a copy of this office's Notice of Privacy Practices, which explains how my protected health information may be used and disclosed.

Acknowledgement of Consent

By signing below, I certify that I am the legal representative, or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understood the above statements. I voluntarily acknowledge, consent and agree to all statements herein. My signature below indicates that the nature of this form was explained to me and that I had the opportunity to ask questions. I understand that this informed consent will become a part of my medical record.

Copies/ faxes/ electronic transmissions of this form and of any and all signatures on this form shall be considered as valid as the originals. All alterations or changes to this form shall be considered invalid and not binding by Hygge Psychiatry.

_____	_____
Patient/ Authorized Signature	Date
_____	_____
Print Name/ relationship of person authorized to sign for patient	Reason patient is unable to sign