## ACKNOWLEDGEMENT AND CONSENT:
## TO THE PATIENT SERVICES AGREEMENT & TO THE NOTICE OF PRIVACY

I have read and understand the information in Dr. Scott Cabot Willis' "Information & Patient Services Agreement." This includes information pertaining to Professional Services, Appointments, Fee Policy & Insurance Reimbursement, Emergencies, and Minor & Parents.

I am aware I have the right to choose the best treatment and provider. I also have the right to refuse or stop treatment at any time and for any reason. I have the right to a detailed explanation of any and all treatment procedures provided by Dr. Willis. If I am not getting the treatment I require, I have the right to raise this concern with Dr. Willis and can expect him to work with me to revise treatment or to refer me to other professionals who may better serve my health care needs. If I have concerns, complaints, or believe a breach of professional conduct has occurred, I have the right to discuss this with Dr. Willis and can expect a professional response, and /or make a formal complaint to the State Board of Psychologist Examiners.

If health care insurance or a third party payor is being used, by signing below, I also agree to have Dr. Willis, and his staff, submit claims to my insurance companies for reimbursement of services provided. I acknowledge I, and not my insurance company, am responsible for full payment of all fees incurred. Payments can be made directly to Dr. Willis.

I understand and agree Dr. Willis may use and disclose health information about me. I understand my health information may include information both created and received by Dr. Willis, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, prescriptions, and similar types of health-related information.

This information may be used and disclosed in order to:

- make decisions about, and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care, and
- perform various office, administrative and business function that support Dr. Willis' efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I understand I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy information sheet, and I understand Dr. Willis is not required by law to agree to such requests.

By signing below, I acknowledge I have received a copy, reviewed, understand, and agree to the information above and in both the Patient Services Agreement (dated July 2019) and the Notice of Privacy (dated July 2019).

_____ _____

Signature of Patient Date Signed

_____ _____

Signature of Patient Representative (parent, legal guardian) Date Signed