



# St. Vincent Sports Performance Center

## Sport and Performance Psychology Services

### CONSENT FORM

The Department of Sport and Performance Psychology is committed to supporting your health care needs. It is our goal to provide you with excellent patient care. This consent form is a general form that will outline authorization for treatment, financial responsibility and release of medical information to entities that are directly affiliated with your health care needs. If you have any questions and/or concerns, please feel free to ask any of our associates for assistance.

#### **Authorization to Treat:**

Permission is hereby granted to the psychologist and/or professional staff of the Department of Sport and Performance Psychology, acting under the supervision of a licensed psychologist, to administer medical care, tests and other services as are considered advisable for my well being, which may also include but not limited to any treatment as deemed necessary. I understand that no partner or associate of St. Vincent Hospital will provide services beyond the scope of their training, certification, and licensure.

#### **Financial Responsibility:**

I hereby guarantee payment in full within thirty (30) days of all charges established by St. Vincent Health for services rendered to me, unless other arrangement satisfactory to St. Vincent Health have been made. This includes any charges that a third party payer may determine to exceed usual and customary limits. I understand that if I am facing financial difficulty I can apply for financial assistance.

I understand and acknowledge that if any unpaid amounts owed by me are assigned to a third party for collection; I will be responsible for paying attorney fees, interest, court costs, and others costs of collection, including collection agency fees.

I authorize Medicare, Medicaid, Blue Shield, and all other commercial payers to pay St. Vincent Health on my behalf for any services furnished to me by the provider.

#### **Release of Medical Information:**

This form also authorizes my physician to release any medical information necessary to process insurance claims, provide necessary treatments, and cover general health care operations. This includes allowing the release of information to any specialty care provider or entity for which that I am referred.

By signing below I certify that I have read and understand the information listed above and , that the information given by me, parent or legal guardian is correct, and that I agree to all of the provisions contained in it.

\_\_\_\_\_  
Patient or Parent/Legal Guardian Signature

\_\_\_\_\_  
Date