The Rizzi Difference
RIZZI MENTAL HEALTH ASSOCIATES

AUTHORIZATION AND CONSENT FOR TREATMENT

Patient Name: _____ **DOB:** _____

Person responsible for bills/statements if other than patient: _____

Address: _____

Phone Number: _____ Relationship: _____

I hereby give my permission for **RIZZI MENTAL HEALTH ASSOCIATES** to evaluate and treat. I understand that continued visits are necessary for monitoring and management. **I understand that I have a choice of provider, and that I may refuse treatment or terminate health services at any time.**

I give consent for Telehealth/telemedicine and understand that there is no additional charge for this service. I give consent for monthly collaborative consultations between psychiatry, primary care medicine, and the interdisciplinary team to monitor patient progress.

Assignment of Insurance Benefits:

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependent. I further expressly agree and acknowledge that my signature on this document authorizes **Rizzi Mental Health Associates** to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or department and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I further acknowledge that any insurance benefits when received by and paid to **Rizzi Mental Health Associates** will be credited to my account in accordance with the above said assignment.

FOR MEDICARE RECIPIENTS: I request that payment of authorized Medicare and Medigap benefits be made on my behalf to **Rizzi Mental Health Associates** for any service provided to me. **Rizzi Mental Health Associates** accepts Medicare assignment. I authorize any folder of medical information about me to be released to Medicare and information needed to determine these benefits payable for services.

Release of Information:

I hereby authorize release to or receive from hospitals, physicians, or other agencies involved in my care all medical records and information pertinent to my care. I hereby give my permission for the review of my medical records by Rizzi Mental Health Associates.

_____ _____
Signature of Patient or POA Date

Verbal consent given by: _____ Relationship to Patient _____

Date: _____

_____
Signature of person completing form if verbal consent is obtained for this patient

Disclosure: Rizzi Geriatrics Associates has an investment interest in Rizzi Mental Health Associates. Rizzi Mental Health Associates is located at 936 Barcarmil Way, Naples, FL 34110. (239) 265-3391. This disclosure is to reiterate that patients have the right to obtain services from a provider of their choice. The names and addresses of alternative clinicians are available to patients. 1. Rizzi Mental Health Associates, 2. Lee Behavioral Health Center, 12550 New Brittany Blvd, Suite 100, Ft. Myers, FL 33907 (239) 343-9180. 3. Dr. Jeffrey Fabacher, 700 2nd Avenue North, #302, Naples, FL 34102, (239) 261-8188. (2022).