MICHELE CAMPIONE, M.D.

TREATMENT CONSENT

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent to psychiatric evaluation and treatment by Dr. Michele Campione. I understand that she does not, and cannot, guarantee any results.

I hereby give consent to Dr. Michele Campione to use and disclose protected health information (PHI) about me to carry out payment operations, namely to submit medical claims on my behalf to my insurance company in order for Dr. Campione to be paid for our sessions.

I give consent to Dr. Campione to:

* Call my cell phone
* Text me on my cell phone, which is not HIPPA-compliant
* Email me

I am aware that there is an inherent risk in any electronic communication with regard to privacy as information can be accessed by unauthorized users in the event of password theft, server malfunction or system hacking.

I have reviewed the above and agree to communication via cell phone, text, and email.

I may revoke my consent in writing except to the extent that Dr. Campione has already made disclosures in reliance upon my prior consent.

Dr. Campione has provided me with her cell phone number. In the unlikely event that I am suicidal and cannot reach Dr. Campione I will call 1-800-LIFENET, 911, or go to the nearest emergency room.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_