CONSENT FOR EVALUATION AND TREATMENT

CONSENT FOR TREATMENT
I authorize Christine D. Forest, M.D. to carry out psychological examinations, treatments and/or diagnostic procedures that now, or during the course of my care as a patient, are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may, at times be difficult and uncomfortable.

CONFIDENTIALITY
All information between psychiatrist and patient is held strictly confidential unless:

1. The patient authorizes release of information with his/her signature.
2. The patient presents a physical danger to self.
3. The patient presents a physical danger to others.
4. Child/elder abuse/neglect are suspected.

I authorize the release of information for claims, certification/case management/quality improvement and other purposes related to benefits of my Health Insurance Plan. (Releases of information to other providers, family, etc., require separate forms.)

CANCELLED/MISSED APPOINTMENTS
I understand that, when I need to re-schedule an appointment, I need to do so at least 24 hours before the appointment in question. Cancellations for Monday appointments need to be received in the office by 3 p.m. of the preceding Friday. Otherwise, the appointment will be considered "missed" and I am responsible for the full cost of that visit.

FINANCIAL TERMS
The cost involved (co-payments, deductibles, or the full fee) for a visit must be paid at the time of each visit. For your convenience, the payment may be made in cash, check or credit card (Visa or MasterCard.)
There is a $20.00 charge for a returned check.
There is a 15% fee applicable for the outstanding charges not paid for two consecutive months.

I understand and agree to all of the above terms.

_____
Patient's Name Printed

_____ _____
Patient's Signature Date