INFORMED CONSENT FOR PSYCHIATRIC TREATMENT

Welcome to ***Professional Psychiatric Services***. This document contains important information about our professional services and business policies. Please read it carefully and make note of any questions you might have so that we can discuss them during our meeting. When you sign this document, it will represent an agreement between us.

PSYCHIATRIC SERVICES
Psychiatry is the medical specialty devoted to the study of mental disorders for the prevention, evaluation, diagnosis and treatment of individuals who are mentally ill.

MEETINGS
We will usually schedule one 45-minute per session for the first psychiatric evaluations, although some sessions may be longer or shorter. Once an appointment hour is scheduled, you will be expected to attend unless you provide **24 hours advance notice of cancellation.**

PROFESSIONAL FEES
Your health insurance provide coverage only for evaluations, treatment and medications of psychiatric conditions. Other services including *report writing, telephone conversations, attendance at meetings with other professionals, preparation of treatment summaries, and the time spent performing any other service you may request of me is not included in the health insurance coverage.*

If you become involved in legal proceedings that require our participation, you will be expected to pay for the professional time even if we have been called to testify by another party. Because of the difficulty of legal involvement, a charge $300 per hour for preparation and attendance at any legal proceeding will be charged to you.

This agreement does not include the use of the psychiatrist as an *expert witness* in any judicial, be it civil or criminal in nature, or administrative proceedings regardless if its state or federal. On the contrary by signing this agrrement patients are obliged to disclose any and all above stated proceedings to the psychiatrist in which they are a party . This prohibition to act as an *expert witness* includes depositions, answer to interrogatories or request for admissions, printed, e-mailed or texted requests, formal or informal requests for information or opinions or any and all other forms of petitions for information relating to an *expert witness.*

However, we will continue with the responsability to send copy of your record to any person or entity authorized by you.

INSURANCE REIMBURSEMENT
If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you are responsible for *full payment* of our services. It is very important that you find out exactly what mental health services your insurance policy covers and what the reimbursement procedure entails.

CONTACTING US

Our contact phone number is 407-734-1273. When we are unavailable, please leave a message and we will return your call as soon as posible during our regular working hours. If it is a an emergency you should call 911 or visit your nearest emergency room.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we have to keep treatment records. You are entitled to receive a copy of your records, if requested in writing.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a physician is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent us from providing any information about your treatment.

TREATMENT TERMINATION

If at any time during the course of your treatment the doctor determines that we cannot continue, we will terminate treatment and explain why this is necessary. You have the right to stop treatment at any time. If you make this choice, referrals to other physicians will be provided.

Your signature below indicates that you have read the information in Informed Consent document and agree to abide by its terms during our professional relationship.

Patient Name _____

Patient Signature _____ Date _____

Relationship to Patient (if applicable): _____

Physician Representative signature _____ Date _____