Informed Consent for Treatment

I, _____ (name of patient), agree and consent to participate in mental health services offered and provided at/by _____ (name of doctor/provider), a mental health provider. I understand that I am consenting to those services that the above provider is qualified to provide within: (1) the scope of the provider's license, certification and training; or (2) the scope of license, certification and training of these mental health providers directly supervising the services received by the patient. If the patient is under the age of eighteen (18), I attest that I have legal custody of this child and am therefore allowed to initiate consent for treatment.

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

Statement of Financial Responsibility

Copayment is expected at the time of my visit. If Dr. Steven B. Israel, MD, FAPA is a provider under my health care insurance plan, I authorize his office to file insurance claims on my behalf.

Unless otherwise specified by a participating provider agreement, I am fully responsible for payment of the total bill incurred. If insurance payment is denied because of my failure to obtain proper authorization, I am responsible for the charges incurred.

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

Consent to Contact Primary Care Physician

I authorize the office to release information about my medical and psychiatric care to my primary care physician and/or to my therapist.

I further authorize the release of medical information to my insurance carrier ot its contracted managed care organizations. Release of some information is sometimes necessary to obtain authorization for services.

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have read, understood and received a copy of the Provider's Notice of Privacy Practices with the effective date of June 20, 2003.

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient