FORT WAYNE PSYCHIATRY, P.C.

Patient's Name _____ Date of Birth _____

CONSENT FOR TREATMENT: I consent to evaluation and medically necessary treatment by professional staff of Fort Wayne Psychiatry, P.C. No guarantee is being made to me about the results of treatment. I can terminate this consent for treatment at any time.

AGREEMENT TO PAY: I agree to pay Fort Wayne Psychiatry, P.C., all charges for professional services. I agree to pay for appointments broken without a 24-hour notice. I also agree to pay for depositions, court appearances, and contact with attorneys related to divorce, custody, visitation, involuntary commitment, social security benefits, disability benefits, and workman's comp issues involving above patient in any way. I will be personally responsible for these charges even if my medical insurance company does not pay. If above patient is covered by Medicare, Medicaid, or an insurance company with which Fort Wayne Psychiatry, P.C., has a binding contract, I will pay only my deductible and co-pay amounts. I agree to pay for charges related to record retrieval, copying costs, and statement of opinion when I authorize release of my records to any outside party. In the event of default I promise to pay such collection costs and attorney fees as may be required to effect collection of the indebtedness.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize and direct payment of benefits under my medical insurance to Fort Wayne Psychiatry, P.C., or its designated professional staff.

FOR MEDICARE RECIPIENTS ONLY: I request that payment of authorized Medicare and Medigap benefits be made on my behalf to Fort Wayne Psychiatry, P.C., for any services furnished me by the professional staff of Fort Wayne Psychiatry, P.C. I authorize any holder of medical information about me to release to the health care financing administration, its agents, and my Medigap insurance company and information needed to determine these benefits or the benefits payable for related services.

PRIVACY PRACTICES: I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

PHOTOCOPIES: I hereby authorize photocopies and electronic copies of this form to be as valid as the original.

The invalidity of any provision of this agreement will not affect the validity of any other provision.

I have read this agreement carefully before signing.

_____	_____	_____
Signature of Patient	Date	Witness

_____	_____
Signature of Insured/Guarantor/Authorized Representative (If different from above)	Signature of Legal Guardian