

Treatment Consent

1. I, _____, consent to psychiatric evaluation and treatment by Michael B. Jackson, M. D. I understand that he does not, and cannot, guarantee any specific results. I understand that his ability to help me/patient depends on the completeness and accuracy of the information provided to him.

2. I consent to the exchange of information, such as diagnoses, medications prescribed, medical records, and diagnostic test results, between Dr. Jackson, hospitals, and other treating professionals when necessary to facilitate treatment. Otherwise, I understand that psychiatric records are confidential and privileged and will not be released to anyone without proper written authorization, unless legally required.

3. I consent specifically to the exchange of information, both for Michael B. Jackson, MD to provide and to receive information including diagnoses, medications prescribed, medical records, and diagnostic test results from the following individuals and providers:

Y N Spouse/Partner/Significant Other: _____ Phone: _____

Y N Therapist: _____ Phone: _____

Y N School counselor: _____ Phone: _____

Y N Primary Care Physician: _____ Phone: _____

Y N Other Medical Specialists: _____ Phone: _____

Y N Other Medical Specialists: _____ Phone: _____

Y N Other (please specify): _____ Phone: _____

Y N Other (please specify): _____ Phone: _____

4. I consent to the release to any third party payer or its agents any information necessary for the processing of a claim for services rendered. Should hospitalization be required, I consent to the release of any information needed for utilization review. Should prior authorization of outpatient treatment or prescription drugs be required, I consent to the release of any information needed.

5. The undersigned agrees, whether he or she signs as guardian, agent or as patient, that in consideration of the services to be rendered to the patient, he or she hereby individually obligates himself or herself to pay the account of the physician. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

6. I agree to the terms of Dr. Jackson's Office and Payment Policies. I understand that I am financially responsible for all charges, and that payments are due at the end of each session. In particular, I understand that I personally must pay the full fee for the time reserved for any appointment which I miss without 24 hours notice.

7. This consent is subject to revocation at any time, by written request, except to the extent that action has been taken in reliance thereon.

Patient Name: _____ Signature: _____

Date: _____

Treatment Decisions

The patient and/or their guardian have the authority to consent to treatment decisions. In making these decisions it is necessary to listen carefully to the opinion of the treating physician. In all medical decisions, no one has the ability to predict the future. All decisions are based upon a weighted decision comparing the risks and benefits of treating vs. not treating. Untreated or inadequately treated illnesses may sometimes have complex and far reaching effects. Conversely, any treatment that may have desirable effects may also have undesirable side effects as well. Since everyone is different, various treatments may have a therapeutic or undesirable side effect in different individuals. Studies are performed to assess safety, tolerability and therapeutic effects in a significant number of patients. Since no two people are exactly the same, no prior study can totally predict a response in any given individual. Occasionally some side effects are evident only after many have been treated for long periods of time. There are many sources of information, some being more reliable than others. In considering treatment options and consenting to treatment decisions, feel free to investigate all sources of information. One source of medical information is the peer reviewed medical literature, some of which is available through the National Library of Medicine at <http://www.ncbi.nlm.nih.gov> Other sources of information include consulting other physicians or practitioners, the *Physician's Desk Reference*, the FDA, and various media outlets. It is important to note that most medical knowledge is yet to be discovered, and there is at times conflicting information within the current medical literature and other sources of information.

You have the ultimate authority in making decisions regarding your health. Open communication with your treating physician regarding beneficial as well as undesirable effects is encouraged to help achieve a better outcome.

Michael B. Jackson, MD

Signature of acknowledgement of above: _____ Date: _____

Office and Payment Policies

Medications:

- To ensure quality of care, regular follow up with routine office visits is necessary for prescriptions to be provided.
- If two or more scheduled office visits have been missed, or the time since last visit exceeds 90 days, the patient must be seen in the office before any further prescriptions are written.

Insurance:

- Dr. Jackson's Office does not participate in any insurance plan other than Consolidated Health Plans.
- Dr. Jackson will provide a comprehensive receipt that can be submitted to an insurance company to facilitate out-of network re-imburement upon request.

Payment:

- All patients are financially responsible for all charges, and payments/co-pay's are due at the end of each office visit
- Dr. Jackson's Office accepts Cash, personal checks, Visa/MasterCard.
- Requests for written reports may incur an additional charge
- There is a \$25 charge for returned checks.

Cancellations:

- Because your appointment time has been reserved for you alone, you will be charged for cancellations/no shows with less than 24 hours notice. Charges for missed appointments must be paid prior to any further appointments can be scheduled.
- Charges for missed appointments are not covered by insurance and are automatically charged to the credit card on file unless prior arrangements are made.
- For patients with Consolidated Health Plans insurance, please note that missed visit charges include the amount normally covered by the insurance company in addition to the copay amount.

I have read and agree to the policies listed above: _____ Date: _____

E-mail/Text Message Policies

- Dr. Jackson periodically utilizes e-mail for scheduling/rescheduling appointments, but e-mail should never be used to convey information of an urgent nature, as prompt responses to e-mail messages cannot be guaranteed.
- To help ensure privacy, patients are cautioned against sending sensitive, detailed or personal information to Dr. Jackson via e-mail, as *the transfer of information via email, unless done so via encryption service, is not a secure or confidential form of communication.*
- Dr. Jackson does not communicate via encrypted email and thus strict confidentiality of email communications cannot be guaranteed.
- Dr. Jackson's office does not send or receive Text Messages of any kind.

Signature of acknowledgement of above: _____ Date: _____

Due to the increased incidents of non-payments, all patients must have a credit card on file.

Please provide Visa or MasterCard (credit or debit) information below. This will only be used in the event of returned checks or other forms of non-payment, unless otherwise requested by the patient. Thank you.

Credit Card # _____

Exp. Date _____ Three Digit Security Code _____

Print Name _____

Signature _____