The Center *for* Healthy Minds

General Consent for Treatment

I hereby consent to and authorize Dr. Halana Rothbort or Dr. Eve Sullivan to evaluate my medical/psychiatric condition and conduct any routine and non-invasive diagnostic and therapeutic procedures and treatments, which in Dr. Rothbort's judgment are necessary for my care. I understand that I have a right to refuse any recommended treatment at any time.

Patient's Name: _____

Patient/Guardian Signature: _____

Date: _____

Patient Payment Information

I understand that Dr. Rothbort and Dr. Sullivan are out of network providers and do not accept insurance. I acknowledge that I am financially responsible for all charges whether or not reimbursed by insurance. I hereby authorize Dr. Rothbort, as my provider, to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions when necessary. In the event that an attorney is required to collect for non-payment of psychiatric care, I acknowledge that I will be responsible for any additional reasonable attorney fees and court costs which are expended.

Responsible Party: _____

Responsible Party Signature: _____

Date: _____

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