

Center for Health Minds
222 Rockaway Tpke, Ste 1
Cedarhurst, NY 11516

General Consent for Treatment

I hereby consent to and authorize all providers employed by The Center for Healthy Minds to evaluate my psychiatric condition. I authorize all providers to conduct any routine and non-invasive diagnostic and therapeutic procedures and treatments, which in the provider'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 The Center for Healthy Minds is an out of network provider and does not accept insurance. I acknowledge that I am financially responsible for all charges whether or not reimbursed by insurance. I hereby authorize 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: _____