David Sikowitz M.D.

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Consent for Treatment

I, _____ consent to the rendering of medical care, which may include psychotherapy, medication or neuromodulation treatment of mental illness and any such treatment as David Sikowitz MD deems necessary. I understand that I am not compelled to engage in psychotherapy, take medication and/or participate in brain stimulation and I may decide to stop it at any time. I understand that it is my responsibility to promptly notify David Sikowitz MD if there are any unexpected changes in my condition and/or if any problems arise relating to my treatment and/or if I do decide to terminate treatment. I also understand that although David Sikowitz MD believes that psychotherapy, medication and/or neuromodulation will help me, there is no guarantee that my condition will improve or as to the results that might be expected. I understand that I have the right to consent or to refuse consent, to any proposed procedure or therapeutic course.

Financial Responsibility and Financial Agreements

I, _____ acknowledge full financial responsibility for services rendered by David Sikowitz MD. I further guarantee that the full and complete payment of all charges for medical care rendered by David Sikowitz MD. This is a guarantee of payment and not merely of collection, and I agree to be directly responsible for the payment of all charges. I understand that the payment of charges incurred is due at the time of services unless other definite financial arrangements have been made prior to treatment. I understand that David Sikowitz MD reserves the right to charge a reasonable, cost-based fee for costs related to copying, labor and supplies, telephone transmissions, and postage incurred at my request.

I understand that David Sikowitz MD may or may not participate in my insurance plan. I understand that I am ultimately responsible for charges incurred. While Dr. Sikowitz's office will make every attempt to settle claims and payment with your insurer, there may be discrepancies that will arise for which you will be financially responsible. Please be advised that a charge equal to the fee for the session will be assessed for appointments cancelled without 24 hours notice.

_____ _____

Patient or Patient's Legal Representative Signature Legal Representative's Name & Relationship

_____

Date