PATIENT AGREEMENT

Sign and give one copy to Dr. Nathan and keep another copy for your records.

CONSENT TO TREAT: I request and give consent to Dr. Nathan to provide, perform and recommend such medical care, tests, drugs and other services as are considered necessary or beneficial by Dr. Nathan for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

KEEPING INFORMATION CURRENT: I agree to inform Dr. Nathan about any changes in my contact information, emergency contact information, health status, medications or allergies.

MONITORING: I understand that psychiatric treatment requires consistent follow-up, and that I am responsible for scheduling and keeping appointments with Dr. Nathan and other evaluation/treatment centers at the intervals that he recommends. I agree to ensure that Dr. Nathan is aware of any problems with medication or changes in symptoms.

EMERGENCIES: I understand that Dr. Nathan or a covering physician is usually available in case of emergency, and that Dr. Nathan has instructions for emergencies on his voicemail. I also understand that unforeseen circumstances may arise in which neither Dr. Nathan nor a covering physician can be reached immediately. If this occurs and I am experiencing an emergency, I will go to the nearest emergency room or call an ambulance.

E-MAIL: If I do not wish to communicate via e-mail, which I understand is a potentially less secure method of communication, I will either withhold my e-mail address or inform Dr. Nathan of this in writing.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT: I have received Dr. Nathan's *Notice of Privacy Practices*.

PAYMENT: I agree that I will pay for all services at the time that services are rendered, unless other arrangements are made in advance. I agree to pay for all appointments that are missed or cancelled with less than twenty-four hours notice, and I understand that insurance companies will not reimburse me for missed appointments. I understand that all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor, regardless of benefits provided by any insurance carrier. I also understand that delinquent accounts may be referred to a collection agency, in which case a 30-50% collection fee will be added. An account will be considered delinquent only if Dr. Nathan's office's efforts to collect payment have failed.

Signature of Patient, Legal Guardian, or Health Care Agent: ***X***_____

Printed Name of Patient: ***X***_____ Date: ***X***_____