Ann Davis, M.D.
Ann Davis Psychiatry, Incorporated
Consent for Evaluation or Treatment

Please take a moment to review some information to which you are entitled before receiving psychiatric services.

Any information you disclose will be maintained in the strictest confidence, unless you specifically authorize its release, or unless its release is required by law or professional standards of practice. In particular, your right to confidentiality may not be maintained if you are an immediate danger to yourself or to someone else, and steps must be taken to assure your own or another's safety. Also, any clinician hearing about domestic violence from a patient or that a child or elder is being or has been physically or psychologically abused is required by law to report this information to a designated agency. If it is necessary to disclose to anyone else information that you have provided, this will be discussed with you.

All visits must be paid for at the time of the visit. At the time of your outpatient visit, you will be provided with an insurance statement to submit to your insurance company. I cannot accept responsibility for negotiating claims with insurance companies or other persons. You are responsible for payment for your medical care regardless of the status of your claim. Any other financial arrangement must be made with me prior to service. Any outstanding bills will be rebilled monthly. If payment is not received after two successive billings, your account may be sent to a collection service.

Should you need to cancel a session, please do so at least 24 hours in advance. Otherwise you will be charged at your regular rate for the cancelled session. Under circumstances where a party other than the patient is responsible for payment, that party must sign a separate agreement guaranteeing payment of the bill. There is a returned check charge of $20.00.

You agree in the event of non-payment to bear the cost of collection and/or court costs and legal fees should this be required.

I have read and understood the foregoing, and I consent to this evaluation or treatment. I have also been provided with the HIPAA Notice of Privacy Practices.

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Signature Date