

MEDICAL CARE

Who is your primary care physician? _____

Please list any significant medical problems you have, including accidents or injuries, hospitalization or surgery

Age?	Illness	Treatment Received	From Whom?	Result?

Do you have any allergies? Yes No

If yes, what are allergic to?	Reaction you have	Allergy medication you take

Consent to treatment and Financial Responsibility: I am seeking psychiatric services from Craig C. Krause, M.D. In order to achieve a successful treatment outcome. I understand that this is a collaborative and cooperative effort between my doctor and me. The following areas are important to maintaining a good doctor — patient relationship.

- I will work with my doctor and his staff to develop a treatment plan in order to meet mutually agreed upon goals that are designed to address my specific mental health needs.
- I agree to take any prescribed or recommended medication only in the manner prescribed.
- I am entitled to full disclosure of the risks, benefits and alternatives to any proposed or prescribed treatment. If I have questions about my medication or treatment, I will contact my doctor.
- I understand that my health insurance is a contract between me, my employer, or insurance company. Dr. Krause is not a part of that contract and as a result, does not file insurance claim forms directly for me. He will however provide any necessary information or documents needed to file claims with my healthcare insurance plan(s) for reimbursement. Failure of an insurance carrier or other third party to pay for services rendered does not relieve me of my responsibility to pay Dr. Krause directly.
- I understand that I will be responsible for all of the costs associated with treatment. I agree to pay the fee that is established by the practice for each service at the time it is rendered. Payment can be made by cash, check, or credit card. We accept Visa or MasterCard. Checks should be made payable to Craig C. Krause, M.D. Checks returned for insufficient funds are subject to a \$35.00 processing fee. I understand I have the right to ask about fees prior to receiving services.
- All services are provided on an appointment basis. This time will be reserved for you and is not available for other patients.
- I understand that timeliness is a foundation of psychiatric treatment. Therefore, to maximize the effectiveness of my treatment, I agree to be on time for scheduled appointments.
- If I cannot keep a scheduled appointment I will cancel my appointment 24 hours prior to the scheduled time. If I fail to do this, I understand I will be charged the full fee for the appointment.
- If I am late for a scheduled appointment, I will be charged the full fee for the appointment, and can only be seen for the remainder of my scheduled session.
- If my doctor cancels my appointment, I will not be charged for that appointment.

By signing this consent I acknowledge that I understand and agree to its terms. Failure to adhere to it may result in the termination of services as unlikely to be reasonably effective or result in improvement. I am aware that I have the freedom of choice of providers and I am choosing Dr. Craig C. Krause, M.D. to provide mental health services to me. I understand that I may withdraw this consent at any time by informing the Practice in writing.

Patient Signature
(Parent / Guardian or Authorized Representative)

Date