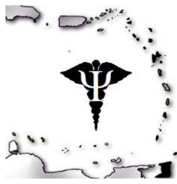

Caribbean MedPsych Limited
9-11 Fitt St. Woodbrook
Trinidad and Tobago
868-224-3460 / Fax 868-623-6529

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

CONSENT FOR MENTAL HEALTH SERVICES (Neuropsychology, Psychology)

I hereby consent to engage in Diagnostic Mental Health Services provided by one or more staff members of Caribbean MedPsych Limited.

FINANCIAL AGREEMENT

I hereby guarantee prompt payment of all charges incurred for services rendered. I agree that my credit card can be billed for any outstanding balance.

RELEASE OF INFORMATION FOR PAYMENT

I expressly authorize any agent of Caribbean MedPsych Limited to release all or part of my mental health record by telephone, by facsimile transmission, by e-mail, or in writing when required by law or government regulation. Caribbean MedPsych Limited, its agents, servants, and employees are hereby released from any and all liability that may arise from the release of such information.

PATIENT RIGHTS

I understand that I have a right to refuse treatment at any time. Unless otherwise agreed to in writing (e.g., Worker's Compensation, litigation), I have a right to review my records, diagnosis, and treatment plan.

RELEASE OF CLINICAL INFORMATION

Information cannot be released without consent except under the following circumstances which may require by law, reporting to the government of Trinidad and Tobago or otherwise releasing information to another party without consent:

1. If there is imminent danger of self-neglect or self-harm or imminent danger to another individual.
2. If there is suspicion of child abuse or neglect.
3. If there is suspicion of elder abuse or neglect.
4. If there is suspicion of abuse or neglect of a disabled individual.
5. If there is suspicion of an inappropriate sexual relationship with a healthcare provider.
6. If legal action is brought involving mental health damages.
7. If there is a court order signed by a judge.
8. If evaluation or treatment is provided with forensic/legal or Workman's Compensation involvement where the client is another individual or agency with whom information may be shared without your consent.

________________________________ ________________________________

Patient Name Patient or Parent/Guardian Signature

Parent or Guardian Name (if applicable): ____

Date:________

PLEASE READ CAREFULLY !!

Fee Agreement

Payment Due Prior to Appointment

Psychological/Neuropsychological Evaluation $________________________

Cogmed Working Memory Training Program $________________________

NO-SHOW and CANCELLATION POLICY

ONCE AN APPOINTMENT IS MADE, YOU ARE FINANCIALLY RESPONSIBLE

You have made a commitment for that day and time and it cannot be easily filled even with several days notice. If there is a serious illness or emergency event that would prevent you from coming to your appointment, you must contact our office as soon as possible and speak directly to Analisa Wittet. Simply leaving a message on the phone canceling your appointment will not relieve you of your financial responsibility.

If the appointment is cancelled 24-48 hours prior to the appointment, one half of the full fee will be charged;, the full fee is charged if the appointment is cancelled less than 24 hours prior to the scheduled examination date, or if the patient no-shows for the appointment.

The fee will be waived if you are able to reschedule the appointment *within the same week* subject to availability. The fee may be waived upon discussion with your staff member.

I certify that I have read and understand the above and I accept all specified terms and fees therein, and have received information on patient rights.

________________________	________________________	___/___/___
Print Patient Name	***Signature*** of Patient, Parent or Guardian	Date