# Young Minds Psychiatry

## Agreement

I hereby authorize **Young Minds Psychiatry**, to provide me _____
Your Name

And or my following dependent _____
Your dependent or child's Name

Psycho-diagnosis, psychiatry, psychotherapy and such other psychological service as are required. I understand that I may withdraw my consent for any specific treatment at any time. I understand that there is no assurance that I will feel better and that in the course of assessment and/or therapy material may be discussed which could be upsetting and thus may be necessary to help me resolve my concerns.

## Confidentiality

I further understand that information about my treatment may not be disclose except for the following reasons:

A. If I sign a waiver requesting release of information
B. If a court orders that a release of my records
C. If I raise my mental status or competency in a legal proceedings
D. If there is reason to believe that there is a high risk to harm myself or other
E. If there is suspicion of child or elder abuse

## Fees

I understand that fees are payable at the time of each treatment session. I authorize the release of any payment, my signature below acts as one on file for billing purposes. I authorize that the release of any payment, medical, psychiatric, and counseling information necessary to process mine or my family member's claims. I hereby authorize to Young Minds Psychiatry LLC, (Anas Alkhatib, MD). I understand that I am financially reasonable to Young Minds Psychiatry LLC, for all charges not covered by the assignment.

## Release of Information

I hereby release my information to Young Minds Psychiatry LLC and/or Other professional who might have service to me. I understand that the nature, of this communication is solely for the purpose of my continuity of my care.

Responsible Party _____ Date_____

Treatment provider/witness _____ Date _____