**Consent for Treatment**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read the “Practice, Fees and Payment Policies For Medication Management, Psychotherapy and Forensic Services” handout and understand that I am responsible for the full payment before the time of service, that Dr. Liu and Dr. Gavett-Liu does not participate with any insurance companies or provincial plans in my province, and that I will be charged for phone appointments, any missed appointments, and appointments cancelled with less than 48 hours’ notice (weekends and holidays excluded). I consent to having my credit card on file and charged for any outstanding balances. I also understand that these services are private and not reimbursed under any Canadian provincial medical plans.

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| Signature of Patient/Parent/Personal Representative | Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Printed Name of Patient/Parent/Personal Representative | Relationship to Patient |