Consent to Treatment:

I consent to allow myself/my child to receive treatment under the care of psychiatrist, Anurag Goel, MD at Psychiatric Excellence (NPI# 1033405592). Treatment may include, but is not limited to: psychotropic medication as well as psychotherapy. I understand that all information between me and my doctor is kept confidential and that Psychiatric Excellence keeps records of my treatment. I understand that in order to provide the most convenient care, Psychiatric Excellence staff and Dr. Goel will use google business email, phone calls, and texts to communicate with me regarding treatment, scheduling, or billing. I consent to the use of email, phone calls, and texts for these purposes. I acknowledge that I have access to Psychiatric Excellence's Notice of Privacy Practices, Member Rights and Responsibilities via the website www.psychiatricexcellence.com which describes my rights as a patient, the limits of confidentiality, and how my private health care information may be used and disclosed. Psychiatric Excellence's policies may change from time to time.

I consent to have my first and last name placed on an appointment list when I have a scheduled visit and given to security in the lobby of the office building.

I understand that New patient appointments are 30 minutes and Follow-Up appointments are 15 minutes.

I consent to have an appointment at least once in two months to ensure that I am doing well and to continue receiving my prescription. If I am being prescribed a controlled substance, I consent to have an appointment more frequently to ensure that I am doing well and to continue receiving my prescription.

When prescribing stimulants, I understand that Dr. Goel usually does not prescribe more than 20 pills per 30 days. I understand that the maximum dose of Adderall he prescribes is usually 20mg, maximum dose of Vyvanse is usually 40mg, and maximum dose of Concerta is usually 36mg.

When prescribing Benzodiazepines (Alprazolam, Lorazepam, and Clonazepam), I understand that Dr. Goel usually does not prescribe more than 10 pills per 30 days.

I understand that Psychiatric Excellence accepts medication refills requests directly from me,. For a medication refill request, I agree to provide notice of at least three business days.

I understand that Dr. Goel does not usually adjust medication dosages or prescribe new medications through email or by phone (an exception may be an emergency situation). I understand that Dr. Goel is only able to adjust medication dosages or start a new medication during an in-person appointment or telemedicine video appointment.

I understand that if I need a letter or form completed, it can only be completed during the time of an appointment. I understand that I must provide notice of at least 10 business days if I need a form completed.

I understand that Psychiatric Excellence does not provide paperwork or make recommendations for Long-Term Disability.

I understand that in order to have paperwork for Short-Term Disability to consider being completed, I need to have a long established relationship with Dr. Goel and have been attending appointments on a regular basis, I need to have an established relationship with a therapist and have been attending their appointments on a regular basis, and that I would need to be participating in an Intensive Outpatient Program or Partial Hospitalization Program.

Insurance Consent:

I authorize Psychiatric Excellence to charge my/my child's insurance company for services provided and to release any medical or other information to my insurance company which is necessary to process claims and/or secure payment of medical services rendered. I assign the insurance benefits to Psychiatric Excellence and authorize and direct my insurance carrier to pay those benefits directly to Psychiatric Excellence. I consent to have my credit card

information saved by Psychiatric Excellence. I understand that it is my responsibility to be aware of my insurance benefits and to determine if Dr. Goel is in-network with my insurance company. I understand that if my medical insurance does not pay for any reason it will be my responsibility to pay the bill in full, unless prohibited by law. I also understand that in the event that I fail to make payments for services rendered to me, my name and account may be turned over to a collection's agency.

Credit Card Consent:

I consent to allow Psychiatric Excellence to store my credit card information on file and charge my credit card without further notice to me for: 1) Insurance copays or coinsurance or my insurance deductible associated with my/my child's doctors' visits, 2) For the cost of my/my child's doctors' visits that are part of an unmet insurance deductible, and 3) For missed sessions or late cancellations with Dr. Goel, that were not canceled by email at least 2 business days (48 hours) before the scheduled session time (See Missed and Late Cancel Policy below), my credit card will be charged $150 for a missed session with Dr. Goel. I understand that Psychiatric Excellence will bill my insurance for my treatment, but that I am ultimately responsible for the charges associated with my care. I affirm that all of the credit card information I have entered is up to date and valid and that I assume responsibility for keeping it up to date and valid. I also understand that if any charges on my credit card are shown to be incorrect, Psychiatric Excellence will issue the appropriate refund to my credit card.

Missed and Late Cancel Office Policy:

Our office requires two full business days' notice (48 hours) to cancel or reschedule your appointment or your credit card will be charged a late cancellation fee. Saturdays, Sundays, and Legal Holidays are not counted as business days (i.e., if you have an appointment on Monday at 11:00 am, and you wish to change it without penalty, you would need to call our office on the preceding Thursday morning before 11:00 am to avoid the late cancellation fee). **The late cancellation fee is $150** for a session with our psychiatrist, Dr. Goel**.** If you are not present at the start time of your scheduled appointment, it may be marked as missed by your provider. Unfortunately, we cannot bill your insurance for late cancellations, missed sessions, appointments with too little time so we apologize that there are no exceptions to the late cancellation policy.

NOTE TO INSURERS ON PATIENT CONSENTS REGARDING HIPAA, PATIENT BILL OF RIGHTS, AND PRIVACY POLICIES

The Consent to Treatment, which all patients in our practice sign, contains a link to an online document describing Psychiatric Excellence's Privacy Practices, Member Rights, and Responsibilities. This document can be found at https://www.psychiatricexcellence.com and includes a description of all patient rights under HIPAA.

Print Name: _____

Signature: _____

Date: _____