Cal Psychiatric Services

Akindele Kolade, MD
3201 S. Maryland Pkwy., Suite 318
Las Vegas, NV 89109
Ph. (702) 629-7490 Fax. (702) 629-7685

I, _____

Address: _____

City\State: _____

Phone: _____

Hereby authorize Cal Psychiatric Services to conduct psychiatric evaluation, diagnosis and treatment of me (or my child). _____

I understand that records concerning my (my child's) treatment will be retained. Such data will be kept confidential. No information about me (my child) will be released without my written consent, except in the case of a medical emergency, or as permitted by law.

Patient Financial Consent Form

Please Initial

_____ I have been informed of financial responsibility involved in my (my child's treatment). Unless arrangements have been made in advance, full payment will be required at the time of each visit.

_____ Rescheduling/Cancellation/No-Shows policy is 24 hours' notice before the time of the appointment. Rescheduling/Cancella ions/No-Shows with less than 24 hour no ice before the appointment ime will be charged full customary fee of $50.

_____ In case of an agreement to bill insurance, deductibles and co-payments will be collected at the time of each visit. **Patients are ultimately responsible for all payment of fees.**

_____ In the event that you cancel or miss 3 appointments with less than 24 hours' notice, we will have to refer you to another doctor for treatment.

Signature: _____ **Date:** _____

☐ Patient ☐ Parent ☐ Legal Guardian ☐ Witness