AUTHORIZATION FOR SERVICES,
CONSENT FORM & STATEMENT OF FINANCIAL RESPONSIBILITY

1. CONSENT TO TREATMENT:

I authorize and request Larry K. Grubb, M.D., to provide such evaluation or treatment that, in his judgment, is advisable for myself or my children. I understand there is no guarantee/warranty made as to the results of such evaluation or treatment. I also understand that I am being seen as a private client
or patient of Dr. Grubb and that Dr. Grubb's services for me or my family have no connection with any hospital, university or other facility where he may be associated. Dr. Grubb maintains a recorded voice mail paging/message service. In the event of an urgent situation, and there will be times when Dr.
Grubb cannot be reached, I will access the appropriate emergency response network of the community, including 911, local hospital emergency room, County Mental Health, law enforcement, or others as appropriate.

Your initial session will last up to 60 minutes (for adults) and up to 90 minutes (for children and their families). Prior to making treatment recommendations, it may be necessary to first gather collateral information from other mental health or medical professionals which are not immediately available. In this case an additional 30 minute appointment will be made to provide the time to discuss this
information as well as develop a comprehensive treatment plan.

By my signature, I confirm that I am fully able to provide an informed consent for myself and for my children. I also confirm that I have fully discussed with Dr. Grubb the various aspects of future services which could include a medication, psychotherapy, evaluation, and/or other methods of treatment or consultation. The nature of the treatment, evaluation or other services has been described,
including its extent, its possible risks or benefits, limitations and possible alternative forms of treatment. I understand that, in the future, if I proceed with an ongoing treatment plan, that it may be periodically adjusted by Dr. Grubb at his discretion. I understand there are federal laws which provide me privacy protections and rights. The Health Insurance Portability and Accountability Act (HIPPA) is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA
requires that I provide you with a Notice of Privacy Practices (The Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is separate from this Agreement, explains HIPPA and its application to your personal health information in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of our first session.

2. PATIENT RECORDS:

I understand that all records pertaining to my care or the care of my family are, in general, confidential but there are exceptions. I understand that disclosure without my consent will be made in cases of suspected child abuse/neglect, elder abuse, or dangerousness to myself or others, where there is a duty for Dr. Grubb to take actions to protect. I understand Dr. Grubb is permitted to make disclosures when my identity is not revealed and Dr. Grubb is consulting with colleagues. Disclosures may be required by health insures, to collect overdue fees, cooperation with government agencies pursuant to their legal authority, if a patient files a complaint or lawsuit or if a patient files a worker's compensation claim, Dr. Grubb can disclose information to the worker's compensation insurer. You should be aware that pursuant to HIPPA, I keep Protected Health information about you in your clinical health record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, medication trials and outcomes, the goals that we set for treatment, your progress towards those goals, your medical and social history including relevant laboratory tests and procedures, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances in that disclosure would physically endanger you and/or others or makes reference to another person (unless such other person is a health care provider), you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Records, you have a right to review (except for information supplied to me confidentially by others), which I will discuss with you upon request.

I understand it is Dr. Grubb's policy to provide information about the progress of treatment about me or my children, but Dr. Grubb shall, at his discretion, keep confidential certain communications by children and patients younger than 18 years of age.

3. PHYSICAL EXAMS:

Dr. Grubb strongly recommends that you (or your child) have a comprehensive physical prior to your first visit. This will enable Dr. Grubb to discuss pertinent findings from the

medical history and physical with your primary care provider. Mental health or medical practitioners will not be contacted without prior written consent.

4. PROFESSIONAL RELATIONSHIPS WITH OTHER PROVIDERS:

Frequently, a multidisciplinary team is needed to address the range of problems facing the identified patient. Problems may include biological, psychological, developmental, academic, family, cultural, and/or spiritual issues. Dr. Grubb does not have supervisory relationship with any other mental health or medical practitioners. As such, it is assumed that prior to initiating treatment with other mental health or medical persons caring for yourself and/or your child you have ensured that they are appropriately licensed and that that person(s) practices within their professional areas of competence as well as practices in accordance with their professional ethical standards. I understand that each mental and medical professional is solely legally and ethically liable for the services he or she provides.

5. FINANCIAL RESPONSIBILITY:

I understand and agree to pay the charges discussed with me by Dr. Grubb for his professional services and agree to be responsible for such expenses for myself or my family. The fee is $200.00 per hour (or $100 for a half hour) for professional services including, but not limited to, the initial consultation and history for outpatient psychotherapy or psychopharmacology, follow up appointments for medication or psychotherapy. Brief phone conversations are not charged. I understand Dr. Grubb will discuss my case with other mental health or medical professionals without charge. I understand that I am responsible to pay all the fees described in this agreement. Dr. Grubb **does not** participate in any insurance billing. I understand that I am financially responsible for all charges which are due immediately at the time of service.

I understand that I will be charged for appointments which are not canceled at least 24 hours prior to the appointment time. Non-payment after 30 days will be considered late. I understand and agree to a $5 or 1.5% monthly interest rate and/or collection procedures and necessary costs if payment is greater
than 30 days late.

I certify that I have read, or have had read to me, fully understand the above, and agree to abide by
these conditions.

_____ _____
Printed Name of Responsible Party Signature

_____ _____
Address (which will be used for mailing) Date

_____ Phone #_____