FINANCIAL AGREEMENT

PATIENT NAME: _____ PATIENT SSN: _____

EMPLOYER:_____

I understand that my first visit will be a consult visit for assessment of my needs and that it is not a consent for medical sponsorship by Dr. Faulkner. We will first talk about why I am here and about the problems I am currently experiencing. Then together we will make a follow-up plan. I understand that Dr. Faulkner may decide my follow-up needs would best be met by referral to another clinician/physician.
Patient initials _____

I understand that all services rendered are my financial responsibility and that payment is due when the medical sponsor relationship begins. I will be required to pay in full all fees for medical sponsorship by Dr. Faulkner. I further understand that failure to pay fees for services rendered will result in my account being turned over to an attorney or collection agency by suit or otherwise and that in the event this occurs, I will be responsible for all collection costs, attorney fees, and any other reasonable collection costs that are necessary for the collection of any amount not paid when due. If I need to establish a payment plan, I will discuss this with Dr. Faulkner.
Patient initials _____

I understand that I will be charged $50.00 per 30 minute increment scheduled for missed appointments unless cancelled 24 hours in advance. I understand missed visit/late cancellation fees must be paid prior to rescheduling with this office and that there are no exceptions to this policy.
Patient initials _____

I have received a copy of the Notice of Privacy Practices for Protected Health Care Information.
Patient initials _____

_____
Patient Signature Date

SERVICE AGREEMENT AND CONSENT

Please read the consent form below carefully. It is important that you understand the kinds of services you will be provided and the terms and conditions under which these services will be offered. If you have any questions, we will be happy to discuss them with you.

Dr. Faulkner and you will first talk about why you are here and about the problems you are currently experiencing. This will also include questions about you and your family's history. The needs for each patient are different and therefore must be assessed individually.

You are responsible for your sobriety. Dr. Faulkner will assist you with your re-certification through the FAA. **He does not guarantee a timeline for case submission nor re-certification**. Each person's recovery is different. Dr. Faulkner will help you sort through and evaluate your options; however, you are the final decision maker. In working with Dr. Faulkner, **it is required that you comply with follow-up care plans as detailed in your discharge summary.**

Accomplishing recovery goals requires your cooperation and active participation. Lack of cooperation may substantially interfere with Dr. Faulkners' ability to effectively render services to you. Under such circumstances, Dr. Faulkner may discontinue services to you and refer you to another physician.

Dr. Faulkner takes seriously the responsibility to hold in confidence what you share with him. Written permission is required to release any information to another agency or to receive any information from another agency. The only exceptions to this policy occur when he suspects elder or child abuse or neglect or when he believes there is a serious threat to harm yourself or another person. He is required by law to notify the appropriate agency should any of these issues arise.

Please feel free to raise any concerns with your physician at any time. If you are dissatisfied with this office we ask that you speak to Dr. Tullis' Nurse Manager, about any concerns you may have.

I request medical sponsorship by Thomas B. Faulkner, MD. As a condition of that treatment, I acknowledge the above items and agree to them. I certify that I have read, understood and accepted this Service Agreement and Consent. This contract covers the length and time of medical sponsorship.

_____

Patient Signature **Date**

Authorization to disclose information to
Primary Care Physician

Primary Care Physician's Name:

Primary Care Physician's Address:

Primary Care Physician's Telephone #:

PRINT NAME

Please *initial* all that apply:

_____Do not have a Primary Care Physician.
initial

_____Do ***not*** authorize Dr. Faulkner to release any information to my Primary
initial Care Physician

_____ Authorize **Thomas B. Faulkner, MD** to release any applicable healthcare
initial information (including medical records, psychotherapy records, evaluation findings, treatment recommendations, progress reports, appointments, laboratory or other diagnostic test information, and medications prescribed) to my Primary Care Physician (listed above).

_____Authorize my **Primary Care Physican** (listed above) to release any
initial applicable healthcare information (including medical records, evaluation findings, treatment recommendations, progress reports, appointments, laboratory or other diagnostic test information and, medications prescribed) to Thomas B. Faulkner, MD.

_____

Signature of Patient Date