

Jamie Gavin, Ph.D., M.P.H.

P.O. Box 161, College Place, WA 99324
(509) 386-6524

GENERAL CONSENT FOR SERVICES

I, _____, hereby give my consent to receive services from Jamie Gavin, Ph.D.

FINANCIAL AGREEMENT: I agree to pay Jamie Gavin, Ph.D. according to his regular rates and terms for services to be rendered to me. I understand that I am financially responsible for charges not covered by my insurance. I understand that I am responsible for any deductible and coinsurance.

ASSIGNMENT OF BENEFITS: I authorize payment directly to Jamie Gavin, Ph.D. of all insurance or health plan benefits otherwise payable to me, to the extent of the patient's bill.

CONSEQUENCES OF BEHAVIOR: I understand that behavior which could result in modification of, suspension of, or discharge from services include, but are not limited to (a) bringing weapons of an sort tot he treatment facility, (b) behaviors that compromise the health and safety of myself and others, and (c) behavior that significantly disrupts the delivery of services to myself and others.

Signature _____ Date _____