Howard Askins, M.D., J.D.
Psychiatry for Adolescents, Adults & Geriatrics
960 East Green Street, Suite 202
Pasadena, CA 91106

Patient Consent Form

Financial Terms: Upon verification of health plan/insurance coverage and policy limits, we will bill your insurance carrier for you as a courtesy and your provider will be paid directly by the carrier. You(patient or guardian) will be responsible for any applicable deductibles and co-payment. If you are not eligible at the time services are rendered, you are responsible for payment. Co-payments are expected to be paid at the time services are rendered.

Cancellations/Missed Appointments: A scheduled appointment means that time is reserved for you. If an appointment is missed or canceled with less then 24 hours notice you may be billed according to the rules of your health plan.

Appeals and Grievances: You have the right to request reconsideration in the case that outpatient care(number of visits) is not authorized. This is called an appeal. You can request an appeal through your provider or through your health plan. You risk nothing in exercising this right. You have the right to submit a complaint directly to your provider or to the health plan to which you belong at anytime, if you have a complaint about any aspect of your care.

Emergencies: If you are in imminent danger call 911 or your nearest police department or emergency room. Our office provides 24 hour, 365 day a year telephonic answering service for urgent matters. If your are truly experiencing a psychiatric crisis you can contact your provider through this service by calling our office at 626-793-7792 please follow the phone instructions carefully.

Confidentiality: All information between the Therapist / Doctor and patient is held strictly confidential unless:

1) You authorize release of information with your signature (or parent / guardian)
2) In compliance with a legal request such as subpoena
3) You present a danger to others
4) You present a danger to self
5) Child or elder abuse is suspected

We are required by law to inform potential victims and legal authorities so that protective measures can be taken.

Consent for Treatment: I further authorize and request my provider to carry out psychological examinations, psychotropic medication evaluations, treatment, and / or diagnostic procedures which during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement.

Release of Information to the Health Plan: I certify that I have insurance coverage and assign directly to my provider all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. My provider may use my healthcare information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment plan is complete.

Fees for Paperwork Completion: Our office reserves the right to charge a minimum fee of $25.00 for the completion of any forms or letters.

I understand and agree to the above:

Patient/Guardian's Signature_____ Date_____

Print Name_____