PSYCHIATRIST-PATIENT/CLIENT SERVICES AGREEMENT
FRAUKE C. SCHAEFER, MD, INC.

I. ***(This must be signed prior to your first session.)***

I have received a copy of the Frauke C. Schaefer, MD, Inc. PSYCHIATRIST-PATIENT/CLIENT SERVICES AGREEMENT and a copy of the Frauke C. Schaefer, MD, Inc. PRIVACY NOTICE.

_____ _____
Name (Patient or Representative) Date

_____
Relationship to Client

II. ***(This must be signed during your first session.)***

I have read, understand, and accept the following by initialing each item:

_____ that Frauke C. Schaefer, MD, Inc. may disclose Protected Health Information as necessary to my insurance company if I want my insurance to be filed. If this is not initialed, I understand that I must pay in full for services.

_____ that Frauke C. Schaefer, MD, Inc. may use Protected Health Information within the practice for the purpose of Treatment/Consultation

_____ that Frauke C. Schaefer, MD, Inc. may share Information as necessary with my primary care physician. If you do not wish information to be shared with your physician initial the "no" block below.

____ NO, do not share information with my physician

Please initial the following if Frauke C. Schaefer, MD, Inc. staff:

_____ may contact you or leave messages at your **home** telephone number

_____ may contact you or leave messages at your **work** telephone number

_____ may contact you or leave messages at your **cell phone** telephone number

_____ may contact you by **e-mail,** if desired specify address_____

I have read, understand, and accept all of the provisions of the Frauke C. Schaefer, MD, Inc. PSYCHIATRIST-PATIENT/CLIENT SERVICES AGREEMENT and the Frauke C. Schaefer, MD, Inc. PRIVACY NOTICE.

_____ _____
Name (Patient/Client or Representative) Date

_____
Relationship to Patient/Client