SHANTHI MOGALI, MD
ADULT PSYCHIATRY AND/OR SUBSTANCE ABUSE TREATMENT

PATIENT AGREEMENT FORM

Patient Name_____DOB_____

I agree to the following conditions in order to receive treatment from Dr. Mogali.

1. **PAYMENT OF FEES:** I agree to pay charges for services as discussed with my provider and may request a written fee schedule. Dr. Mogali may change her fees in the future. Payment in full for oupatient treatment must be made by or before the second visit.

2. **RELEASE OF CONFIDENTIALITY for AUTHORIZATION OF BENENFITS:** I authorize Dr. Mogali to provide my insurance plan or managed care plan any information reasonably required to obtain health benefits and authorization for services.

3. **RELEASE OF CONFIDENTIALITY for CLINCAL CARE:** I authorize Dr. Mogali to obtain at any time during my treatment, any and all relevant clinical information from clinicians and facilities who have treated me and to furnish clinical information to providers who will continue to treat me. I will indicate in writing any exceptions to this.

4. **CONDITION OF TREATMENT:** I understand that Dr. Mogali reserves the right to stop treating me if I do not adhere to this agreement.

Name of Responsible Party_____
Signature_____ Relationship to patient_____
Address of Responsible Party_____
_____
Phone number: W_____ H_____C_____
Email:_____
Witness: Print: _____Sign:_____

Credit Card Authorization for Payment/Fees:
Credit Card Type: _____ Security Code_____
Credit Card Number:_____
Exp Date:_____ Billing Zip Code_____
Signature_____Date_____