Dr. Michael P. Twist – Psychiatry, LLC

16 Brace Road, 2nd Floor
West Hartford, CT 06107
(860) 967-0405

Consent to Treatment and Agreement

It is the policy of Dr. Michael P. Twist – Psychiatry, LLC to expect that payment be made at the time that services are provided unless special arrangements have been made in advance.

Please contact your insurance provider to ensure that the services you are requesting are covered and whether such services require pre-authorization. It is expected that you will do so prior to your first appointment. Dr. Twist is not responsible to verify your coverage and cannot guarantee payment. If your insurance company requires additional information, Dr. Twist will gladly help you in obtaining authorization.

By signing this form you are agreeing to submission of insurance claims to your insurance provider, at times through electronic submission, and that Dr. Twist may release the requested information about you and your treatment in order to process such claims including diagnosis, treatment plans and if necessary, your treatment record. By signing this form you are acknowledging that you are aware that you are ultimately responsible for payment for the services you receive in the event that your insurance provider does not cover them.

By signing this form you are also agreeing to the policy of providing 24 hours' notice for all cancellations. You are also agreeing that you are aware that you will be billed directly for missed appointments or those cancelled less than 24 hours in advance. These missed or cancelled appointments cannot be billed to your insurance provider. Telephone calls lasting longer than 15 minutes are also subject to charges.

By signing this form I agree that I have read and understand the above policies and accept responsibility for my account. I also agree that billing statements and other mailings can be sent to my home address unless I provide an alternative address. I agree to treatment from Dr. Michael P. Twist, Psychiatrist of Dr. Michael P. Twist – Psychiatry, LLC.

Signature of client: ____ Date: __________________