Dr. Edward Anthony Allen, MB, BS, M Div,
DPM, MRC PSYCH, DM (PSYCH)
Consultant Psychiatrist
OXFORD MEDICAL CENTRE
22H Old Hope Road, Kingston 5.
Telephone No. (876) 926-1444-6 / 926-1525-6

INFORMED CONSENT

(**NOTE:** Clients must be adequately informed of their rights and responsibilities. I am, therefore, asking that you read the following carefully before signing).

I seek to provide services as specified on the brochure entitled "INFORMATION FOR PATIENTS".

ON YOUR PART

1. You undertake to pay at the end of each session, the fee per session. All cheques are made payable to **Dr. E. Anthony Allen**.
2. You undertake to pay **50 %** for all scheduled sessions **unless you cancel at least 24 hours before your scheduled appointment. Exceptions are made only in an emergency, at my discretion.**
3. **Except for when unavoidable circumstances necessitate these, repeat prescriptions will attract a fee of $1000.00**
4. If I counsel with your spouse or family member, **you are hereby agreeing not to subpoena me or any records relating to my counselling of your spouse or family member.**
5. If I provide therapy for your spouse or family member, should I ***(Please initial the appropriate response)***:

   Check with you before sharing information or observations about you with your spouse or family member?

   or

   Use my own judgement in sharing information or observations about you with your spouse or family member?

   or

   Not disclose any observation except in your presence?

   or

   Consult with other professionals?

6. Please arrange to have a **thorough physical examination** within a few weeks of therapy, if you have not had one within the last 12 months. Kindly provide me with a report of the findings.
7. The initial stages or early sessions of therapy are sometimes difficult and uncomfortable for most people. If at any time during therapy, you develop negative or positive feelings towards me, please let me know so that we can discuss them openly.