



Psychiatric Services of
Central New York

Creating Balanced LivingSM

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Consent for Treatment

I voluntarily give my permission to the health care providers of Psychiatric Services of Central New York, and such assistants and other health care providers as they may deem necessary to provide medical services to me or for the patient for whom I am the parent or legally authorized representative. I understand by signing this form, I am authorizing them to treat me or the patient for as long as I seek care from Psychiatric Services of Central New York, or until I withdraw my consent in writing.

Signature of Patient or Guardian

Date

Printed Name of Patient or Guardian

Relationship to Patient

Statement of Financial Responsibility

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of Psychiatric Services of Central New York, regardless of the patient's insurance status. I assign and authorize payments to Psychiatric Services of Central New York. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, if any, and policy deductibles and co-insurance.

Signature of Patient or Guardian

Date

Printed Name of Patient or Guardian

Relationship to Patient