CAIRN CENTER

SHAILY JAIN, M.D.

3615 West Charleston Boulevard Las Vegas NV 89102 shailyjain7@gmail.com
Phone and Fax : 702-508-9461 www.cairncenter.com

CONSENT TO TREATMENT

I, voluntarily, agree to receive Mental Health assessment, care, treatment, and authorize the Dr. Shaily Jain to provide such care as is considered necessary and advisable in her professional judgement. I agree to participate in the planning of my care and I may stop treatment at any time by informing my psychiatrist. I have access to a copy and have read and understood all the terms and information contained in the Practice Guidelines and Consent to Treatment Form and Notice of Privacy Practices.

_____

Print Name Signature Date

Request for Email Communications: I understand and agree to the following:
I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address. I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communicated this way. I agree to hold Cairn Center and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email. My email address is: _____

_____

Signature Date

PERMISSION FOR RELEASE OF INFORMATION

I hereby give Dr. Shaily Jain permission to release information pertaining to my care to the following person(s) or health care entity:

_____ _____

I understand that this permission is valid for one year after the date signed below, unless I revoke it before that date.

REQUEST FOR RELEASE OF MEDICAL INFORMATION

Name: _____ Date of birth: _____
I hereby give permission for the release of medical information pertaining to myself from the following medical institution or provider(s):

_____

to include all dates within the past **twelve** months, including all diagnosis and discharge instructions, physical exam findings, laboratory and radiology results, psychosocial assessments and treatment plans, to the following health care provider for the purpose of continuity of medical care:

Shaily Jain M.D. Psychiatry
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Phone # 702-508-9461 Fax # 702-508-9461

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Print Name Signature Date