Robin L. Bailey, M.D., Private Practice

**Informed Consent to Treat**

I wish to be treated in the private practice of Robin L. Bailey, M.D. I authorize   
Robin L. Bailey, M.D., to provide treatment that she judges beneficial to me. I understand that this may include tests, examinations, medical treatments, and consultations with appropriate care givers. No guarantees have been made to me concerning the outcome of this care. I understand the details of this practice’s management of protected healthcare information are detailed in the Notice of Privacy Practices referenced below.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Receipt of**

**“Welcome to the practice of Robin Bailey, M.D.,**

**Board Certified Psychiatrist”**

A copy of information regarding the private practice of Robin Bailey, M.D. for my review and reference, titled, “Welcome to the practice of Robin Bailey, M.D., Board Certified Psychiatrist” was made available to me, on the website BaileyMD.com or in paper form.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Acknowledgement of Availability of**

**Notice of Privacy Practices**

**For the private practice of Robin L. Bailey, M.D.**

I acknowledge that I have been offered a copy of “Notice of Privacy Practices for Protected Health Information in the Private Practice of Robin L. Bailey, M.D.”.

I understand that copies of the Privacy Practices are posted in Dr. Bailey’s waiting area and are available in the future at my request.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rev. 9.19