Dr. Greta L. Krause
1729 E. Main Street, Plainfield, IN 46168
Phone: 317-742-5255 Fax:844-711-3169

Consent to Treatment

Patient Name: _____

DOB: _____

Date: _____

I voluntarily consent to outpatient care with Greta L. Krause, DO.

- I understand Dr. Greta L. Krause, DO uses an integrative psychiatry and mental health approach with limited use of medications.

- I understand that the care I receive from Dr. Greta L. Krause may be considered non-conventional. Such services are commonly referred to as integrative, complementary, alternative or holistic services. This can include nutritional and supplement recommendations, mindfulness and breathing practices, and other mind-body approaches to care. While many of these techniques have been long practiced and researched and found to be effective, many are still considered “investigative” or “experimental”. The treatment plan is a collaborative effort and I recognize it is my responsibility to let Dr. Krause know which approaches I would like to try and those with which I do not feel comfortable. I recognize it is entirely my choice. By accepting these treatments I agree to accept the risks explained to me about these treatments.

I have read and understand the foregoing and understand that it is my responsibility to discuss any concerns I have about any and all parts of my treatment plan. I understand the nature of these health care methods and consent to counseling and treatment.

Patient Name: _____

Patient Signature: _____

Signature of Guardian: _____

Date: _____

Credit Card Authorization Form

The information on this form will remain strictly confidential.

If the name on the credit card is different from my own, I do hereby grant permission to Dr. Greta L. Krause to discuss appointments dates kept and missed to the credit card holder as necessary in order to collect payment.

Patient Signature _____

CREDIT CARD INFORMATION

Type of Credit Card VISA American Express Master Card Other _____

Credit Card Number _____

Expiration Date _____

CCV Code _____

Credit Card Billing Address

Street Address _____

_____

City **State** **Zip Code**

As the credit card holder, I authorize Dr. Greta L. Krause to charge my credit card for future services, communications, and late cancellations or no show fees.

Disputes that I have regarding charges will be addressed directly with Dr. Greta L. Krause and staff. I will not dispute charges with the credit card company.

Signature and Date _____