WANT TO SEE DR. COX?

All our patients are self-pay. We work for you; and do not accept insurance. Our fees are $560 for the initial 90 minute visit and $230 for each half-hour visit, frozen until 1/1/21. If you would like to find out if Dr. Cox can accept you as a patient, please print out this page. Fill it out and mail or fax (859.272-7166) to our office (3135 Custer Dr. Lexington KY 40517). Our office manager, Angela, will call you with our decision within a business day of receiving this form.

Your Name:	Please jot down the names of psychiatric medicines you take now, or, are supposed to be taking now. Omit mg and dosing.
Street address	
City	
State	
ZIP Code	
Telephone number	
Are you an attorney? Yes No	
Is your child, sibling or parent an attorney? Yes No	
Have you been on Suboxone or heroin or any opiate? Yes No	
Are you a Soldier or a Veteran? Yes No	
Age in years	
Date of birth	
What is the *general* nature of your difficulty you want help with, no *particulars* needed.	

Social Security or Driver License number. (This is required because of Kentucky's Kasper law. If your case is not accepted by Dr. Cox's office this form will be destroyed by shredder to protect your identity.)	

Consent for Medical Treatment

I consent to be evaluated and, if necessary, to be treated by Dr. Cox. I consent for Dr. Cox and my other doctors to share my medical information for the betterment of my medical care. Even though this would probably never come up, Dr. Cox may talk to my family, if needed, about my condition and treatment; I trust him not to unnecessarily divulge any embarrassing private information to my family by using his discretion and clinical judgment. If I object to this policy I will not make an appointment; and, I may seek treatment elsewhere. I realize that I may be prescribed medicine as a part of my treatment.	As seen on TV ads, all medicines may be said to have virtually any side effect, including irreversible side effects, suicide, death, addiction, and drug abuse. I am aware of this. I have the right to not take medicine. I accept potential side effect risks in order to obtain hoped-for benefits for my symptoms. Taking medicine is completely voluntary. I may taper off it at any time. I understand that payment of bills due is at the time services are received and no credit balance will be possible.

I have read this information and I consent.

Sign your name: **Date:** _____ / ____ /_____