**REFERRAL TERMINATION ACKNOWLEDGEMENT FORM for Baylor IOP/PHP**

**Referral**

In consideration of services provided by Progressive Psychiatry, P.A., I understand that the services offered by Progressive Psychiatry, P.A. during my enrollment in either the Intensive Outpatient (IOP) or the Partial Hospitalization Program (PHP) are separate from outpatient services rendered by Progressive Psychiatry, P.A.; therefore the patient/provider relationship ends after I am discharged from the program.

I understand that if the providers and staff at Progressive Psychiatry, P.A. feel that they can no longer provide excellent patient care to me while enrolled in IOP/PHP, Progressive Psychiatry will provide me with a list of available resources to whom I may transfer my care.

I understand that if I choose to seek outpatient services through Progressive Psychiatry, P.A., I will have to go through their standard Intake process and that acceptance into the outpatient practice is not guaranteed.

**Termination of Services**

I understand I may choose to terminate services at any time with Progressive Psychiatry, P.A. I am also aware that Progressive Psychiatry, P.A. may recommend termination of services for any reason and at any time with appropriate legal notifications as required by the Texas Medical Board.

**Scheduling & Cancellations**

I agree to attend all of my scheduled sessions and to call or email at least 24 hours ahead of time if I will not be able to attend my session for any reason. Failure to do so may result in discontinuation of services with Progressive Psychiatry, P.A. during my time in the IOP/PHP program and/or inability to obtain prescriptions past the date of discharge.

**By signing this form, I acknowledge that I have read and understand all the terms, conditions, & information contained herein. I have been provided sufficient opportunity to ask questions and seek clarification of anything contained in the agreement that is unclear to me; thus I consent to be treated by providers of Progressive Psychiatry, P.A.**

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Patient Name Patient Signature

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Date