Child and Adult Psychological Services, PLLC

EIN: 82-3773654

Psychological Services Consent Form

Client Information:

Date:_____

Client's Name (official):_____

Preferred Name:_____

Date of Birth:_____

Client/ Legal Guardian:

Legal Guardian:_____

Relation to Client:_____

Mailing Address (street address):_____

City, State & Zip code: _____

Cell Phone:_____

Other Number:_____

Email:_____

Permanent Address (If other than mailing):_____

Referral Source (Person/ agency who recommended Child & Adult Psychological Services to you):
Name: _____ Telephone: _____
Address: _____ Relationship to Client: _____

Informed Consent for Psychological Services:
Your signature at the end of this form will indicate that you have read and understood all of the following conditions for treatment.

I voluntarily consent to participation in the assessment, consultation, and treatment that may be performed during the (series of) visit(s) with any staff of Child and Adult Psychological Services, PLLC

I hereby authorize Child and Adult Psychological Services, PLLC or its designated staff to release to any appropriate insurance-related entity or collection agency the information needed to process claims in reference to this treatment.

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I hereby authorize Child and Adult Psychological Services, PLLC or its designated staff to notify the above-named referral source of my having made this appointment. This alone will be disclosed to the referring professional and is done as a professional courtesy.

I understand that payment is due in full at the time of service. Should my account become delinquent and be referred to any third party for collection effort, I agree to pay all reasonable attorney fees, court costs, and a collection expense of not more than 75 percent of any referred balance.

I understand that clients are seen by appointment only and that any appointment cancellation made less than 24 hours in advance of the scheduled time will incur a cancellation fee equal to Child and Adult Psychological Services, PLLC's regular session fee. (Please note that most insurance companies do not reimburse for missed appointment charges.)

I understand that information shared with Child and Adult Psychological Services, PLLC and its designated staff is confidential with the exceptions to confidentiality indicated by federal and / or state law and/ or American Psychological Association's Ethics Code. I have been provided with and have access to detailed information regarding my rights to confidentiality and privacy (including those provided by the Health Information Portability and Accountability Act).

Severability: If any portion or portions of this Agreement shall be, for any reason, invalid or unenforceable, the remaining portion or portions shall nevertheless be valid, enforceable and carried into effect, unless to do so would clearly violate the present legal and valid intention of the parties hereto.

Please sign below and indicate the date that you read and agreed to all of the conditions outlined above concerning psychological services provided by Child and Adult Psychological Services, PLLC and its designated staff. You may request a copy for your records.

Client Signature **Date**

Signature of Parent / Caregiver **Date** **(Relation to Client)**

Signature of Parent / Caregiver **Date** **(Relation to Client)**