**Consent and Agreement for Services**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to allow the psychologist named below to perform the following services:

❑ Counseling

❑ Disability evaluation

❑ Group therapy

❑ Psychological testing, assessment, or evaluation

❑ Report writing

❑ Other (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This agreement concerns ❑ myself or ❑ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that these services may include direct, face-to-face, telephone or virtual contact, interviewing, or testing. They may also include the clinician's time required for the reading of records, consultations with other clinicians and professionals, scoring of tests, interpreting the results, and any other activities to support these services. If I have questions or concerns about this assessment, the evaluator agrees to be available to discuss these after completion of the testing and interviews.

I understand that the fee for this (these) service(s) will be $ \_\_\_\_\_\_\_ per hour, and that this is payable in two parts: a deposit of $ \_\_\_\_\_\_ payable before the start of this (these) services, and a second payment of the balance due on the completion and delivery of any report (or, for depositions, testimony, or other services, at the time these services take place). I understand that I am fully responsible for payment for these services.

I understand that this evaluation is to be done for the purpose(s) of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I also understand the psychologist agrees to the following:

1. The procedures for selecting, giving, and scoring the tests, interpreting the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations and with the applicable state and federal laws.

2. Tests will be chosen that are suitable for the purposes described above. These tests will be given and scored according to the instructions in the tests’ manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.

3. Tests and test results will be kept in a secure place to maintain their confidentiality.

**4. The report of the findings of this assessment will be sent to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of client (or parent/guardian) Date

**Client Information Form**

Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Note****:* If you have been a patient here before, please fill in only the information that has changed.

**A. Identification**

Your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_
Nicknames or aliases: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Home street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_
Home/evening phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ e-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Calls or e-mail will be discreet, but please indicate any restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B. Referral:** Who gave you my name to call? **(PLEASE LIST PROBATION/CASEWORKER INFORMATION IF APPLICABLE)**
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how I might be of help to you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**C. Your medical care:** From whom or where do you get your medical care?

Clinic/doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

**E. Your current employer**

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or other means of communication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D. Emergency information**

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant other/nearest friend or relative not residing with you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to Release Confidential Information**

Name of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the purpose of this release is to assist with my/this patient’s treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the patient’s life. To further this goal, I authorize this specific service provider, therapist, case manager, or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to release the below-specified information regarding me/the patient to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by an X in the boxes below, and any items not to be released have a line drawn through them:

 ❑ Name of therapist ❑ Name of case manager ❑ Name(s) of treatment program(s)

 ❑ Admission/discharge information ❑ Treatment plan ❑ Scheduled appointments

 ❑ Progress notes ❑ Compliance with treatment ❑ Discharge plans

 ❑ Treatment summary ❑ Psychological evaluation ❑ Medications

 ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information is to be disclosed to these persons, who have the indicated relationship to me/the patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person Relationship

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire ❑ one year from this date, ❑ upon my discharge from treatment by this agency or by the person specified above, or ❑ under these circumstances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client Printed name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian/representative Printed name Relationship Date

**Notice of Privacy Practices**

**Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional

care. We are also required by law to keep your information private.

**How we use and disclose your protected health information with your consent**

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

**Disclosing your health information without your consent**

There are sometimes when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another’s health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.

2. When we are required to do so by lawsuits and other legal or court proceedings.

3. If a law enforcement official requires us to do so.

4. For workers’ compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

**Your rights regarding your health information**

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.

2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.

4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above.

TWAC policies

Please initial each section after reading.

\_\_\_\_\_\_ 1.) To maximize the opportunities for services to our clients, we will charge a $50.00 fee for missed appointments or appointments not cancelled within 24 hours.

\_\_\_\_\_\_ 2.) To maximize treatment time and effectiveness, we ask all clients to arrive on time for their appointments. If you are more than 15 minutes late, you may be asked to reschedule the appointment.

\_\_\_\_\_\_ 3.) To maximize treatment time for clients coming after you, please be prepared for your session to end at its scheduled time.

\_\_\_\_\_\_ 4.) Due to limited seating, please do not bring more than one guest to wait in the lobby area while you are being serviced.

\_\_\_\_\_\_ 5.) Clients will be charged a 10% transaction fee for credit card usage.

\_\_\_\_\_\_ 6.) We reserve to right to decline completion of paperwork on your behalf.

­­\_\_\_\_\_\_ 7.) We will not complete any disability, FMLA, employment or financial compensation related paperwork for anyone who has been seen a minimum of 5 sessions by our staff.

\_\_\_\_\_\_ 8.) We will charge a $25.00 fee for 6 or less pages and a $40.00 fee for 7 or more pages of paperwork completed on your behalf.

\_\_\_\_\_\_ 9.) All paperwork to be completed on your behalf must be provided at least 5 business days before the due date to be completed. NO EXCEPTIONS