ALLIANCE
PSYCHOLOGICAL SERVICES

TREATMENT CONSENT/HIPAA/OFFICE POLICY ACKNOWLEDGEMENT

PATIENT NAME:_____ **DATE OF BIRTH:** _____

ADDRESS: _____

CONTACT PERMISSION

APS may contact me at the following phone number(s): _____

YES NO May we communicate with you via text message? Phone number: _____

E-mail address: _____

YES NO May we send you billing statements via e-mail?

YES NO May we send you brief post-session e-surveys?

YES NO May we send you our e-mail newsletter?

PRIMARY CARE PHYSICIAN INFORMATION

Providing your physician's name and/or contact information below signifies that you have given APS permission to coordinate with your physician.

Physician Name: _____

Address: _____

Phone: _____ Fax: _____

EMERGENCY CONTACT

Name: _____ Rel. to Pt. _____

Phone: _____

CANCELLATION POLICY

Please contact us **AS SOON AS YOU KNOW** that you will be unable to keep a scheduled appointment. Appointments canceled less than 24 hours in advance may be subject to **a $50 cancellation fee**. Appointments that are not cancelled and where the client does not show up at least 15 minutes into the start of the scheduled session time will be subject to a **$75 no show fee.** Repeated missed appointments may result in termination of services. Your insurance will not be responsible for a missed appointment fee.

MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND AGREE TO THE TERMS OF THE SERVICE AGREEMENT REVISED 4/21 AND ACKNOWLEDGES THAT I HAVE RECEIVED THE HIPAA NOTICE DESCRIBED THEREIN

Signature:_____ Rel. to Pt._____ Date:_____

(Patient or Parent/Guardian)