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. It is okay to call after hours to leave a message that you will be unable to keep your appointment. Repeated late cancellations and appointments missed without notice may be subject to a no show/cancellation fee. If you have a standing appointment time and miss an appointment or cancel on short notice, we may offer your appointment time to someone on the waiting list if there is one. In that event, we will offer you appointments as they become available.

MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND AGREE TO THE TERMS OF THE SERVICE AGREEMENT REVISED 10/13 AND ACKNOWLEDGES THAT I HAVE RECEIVED THE HIPAA NOTICE DESCRIBED THEREIN

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

(Patient or Parent/Guardian)