NEUROPSYCHOLGOCIAL & CLINICAL PSYCHOTHERAPUTIC SERVICES, LLC

ACKNOWLEDGEMENT OF RECEIPT OF PRIVATE PRACTICE NOTICE & CONSENT TO TREATMENT

I hereby voluntarily enter into services or give my consent for the minor or person under my legal guardianship to have assessment/treatment provided by a clinician affiliated with Neuropsychological & Clinical Psychotherapeutic Services, LLC (NeuroPsychCPS). I agree to play an active role in all parts of the assessment/treatment process. I understand that no promises have been made to me as to the results of assessment/treatment or any procedures provided by the clinician.

I understand that the services may be discontinued at any time by either party. If services is discontinued, I will be responsible for payment for services already received. I understand that I may lose other services or may have to deal with other consequences if I stop assessment/treatment. I also understand that my symptoms may worsen if I stop treatment prematurely and do not pursue other services.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I fail to attend a scheduled appointment and do not cancel, I will be charged for that appointment.

The confidentiality of patient records maintained by NeuroPsychCPS, is protected by Federal and/or State law and regulations. Generally, the therapist may not acknowledge to a person other than those employed within the therapy office that a patient is in treatment unless:

1) The patient consents in writing.
2) The disclosure is allowed by a court order.
3) The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Clinicians are required by state law and professional obligations to report allegations of abuse or neglect of children or vulnerable adults to the appropriate authorities.

I am aware that an agent of my insurance company or other third party payer may be given information about the type(s), cost(s), date(s) and provider(s) of any services or treatments that I receive. I understand if payment for the services I receive here is not made by a third party payer, I will be responsible for the balance. If payment for services is not received, the clinician may terminate treatment.

My signature acknowledges that I have received a copy of NeuroPsychCPS Notice of Privacy Practices. I hereby consent to assessment/treatment and agree to abide by the above stated policies and agreements. I understand that NeuroPsychCPS has a right to amend these practices at any time and I may obtain a current copy by contacting NeuroPsychCPS.

Client's Printed Name: _____ Date of birth: _____
(First, Middle Initial, Last) *(MM/DD/YYYY)*

Signature of Client
Or Legal Representative: _____ Today's date: _____
(First, Middle Initial, Last) *(MM/DD/YYYY)*

If signed by Legal Representative, relationship to client: _____