Carol C. Hamilton, Psy.D
Clinical Psychology Services
Intake

Name of Client: _____ Date of Birth _____
Preferred Pronouns she/her, he/him, they/them _____
Mailing address: _____
_____Zip Code_____
Preferred Phone: _____
Best times to call: _____ Okay to Text? ____Yes _____No.
Insured's Name if different from client: _____
Insured's date of birth: _____Employer: _____
Health Insurance: _____Policy: _____
Group Number: _____Co-Pay: _____
Primary Care Provider and Phone: _____

Informed Consent for Psychological Treatment

Please read each item and ask any questions that you might have about your psychological treatment.

1) I understand that my treatment will not be discussed with others without my consent unless Dr. Hamilton has reason to believe that the failure to discuss my condition might result in serious harm or death to myself or another. I understand there are exceptions to confidentiality under HIPAA and the APA ethical code.

2) I am aware of HIPAA requirements and understand that HIPAA describes certain exceptions to confidentiality. _____ (Please Initial.)

3) I understand that my insurer or managed care company will require a diagnosis and/or other confidential information in order to authorize or pay for my treatment and consent to Dr. Hamilton obtaining that authorization and/or payment. _____ (Please Initial if applicable).

4) I freely consent to my psychological treatment and understand that that I may terminate treatment at any time. I understand that there are no guarantees as to the outcome of treatment. I agree to inform Dr. Hamilton about how my psychological condition is progressing, and to avail myself of additional emergency services such as an afterhours call to one of the crisis phone numbers on Dr. Hamilton's phone message, a trip to a hospital emergency room, or a call to 911 if my life is at risk.

5) I understand that insurance billing is done through a HIPAA compliant billing company that uses electronic billing and I give my consent for electronic billing. _____ (Initial if applicable)

6) I accept the responsibility of informing myself about my insurer and paying for services that my insurer does not cover or declines. I agree that I am responsible for my hourly co-payment or agreed upon fee which is: _____.

7) I understand that parents seeking treatment for a minor child may request a conference at any time with Dr. Hamilton and are encouraged to call to provide information and progress reports on a regular basis. I understand that except for issues of safety, Dr. Hamilton will respect the child or adolescent's wishes for privacy. I understand as a parent that I may communicate any and all of my concerns about my child to Dr. Hamilton by phone or in a scheduled appointment_____ (Please initial).

8) I understand that scheduled appointments must be cancelled 24 hours ahead of time and those late cancellations or no shows cannot be billed to my insurer. I agree to pay a fee of $75.00 for sessions not cancelled ahead, but understand that Dr. Hamilton does understand the occasional emergency situation or sudden illness and will consider those circumstances on a case by case basis for those circumstances. I agree to make every effort to notify Dr. Hamilton in advance of my appointment if I believe illness or other circumstances will prevent me from meeting at the appointment time I have reserved. _____. HOWEVER, YOU ARE STRONGLY ENCOURAGED TO STAY HOME IN THE EVENT OF ANY CONTAGIOUS and/or UPPER RESPIRATORY ILLNESS AND CAN MEET BY PHONE OR ZOOM IF YOU ARE WELL ENOUGH TO DO SO. (Please initial). _____

9) IN CASE OF EMERGENCY OR ANY POTENTIALLY LIFE-THREATENING CONDITION I AGREE TO CALL 911 OR GO TO THE NEAREST HOSPITAL EMERGENCY ROOM, OR TO ARRANGE THIS ON BEHALF OF ANY MINOR CHILD. _____(Please initial)

_____ _____

Name of Client and/or Guardian **Date**

_____ _____

Dr. Carol C. Hamilton **Date**