

HEALTH PSYCHOLOGY ASSOCIATES

245 Mt. Rose Street

Reno, NV 89509

775-448-6828 Fax 775-322-2964

Deacon Shoenberger, Ph.D.

Natalie Sanchez, MFT

Angela Fuller, CPC

Informed Consent – Provision of Services by a licensed Master’s Level Therapist

I, _____, as a recipient of outpatient mental health services at Health Psychology Associates, understand that:

- My counselor has completed a Master’s Degree in Clinical Mental Health Counseling and is currently a Licensed Clinical Professional Counselor.
- Information about my case may be presented in an individual supervision milieu for the purposes of professional development and/or improved quality of care.
- In order to protect my privacy, information shared will be done so with the least amount of identifying information possible.
- My counselor is currently in a supervision group which contains the following supervisors:
Deacon Shoenberger, Ph.D. and Natalie Sanchez, MFT.
- I have a right to refuse the disclosure of personal information to specific members of the supervision group where a conflicting relationship may exist. If such a relationship exists, it is my responsibility to address this with my counselor.

By signing this authorization for treatment by Angela Fuller, CPC, I acknowledge that I have read and understand the information above and

_____ I consent to treatment with the supervisory arrangement as specified.

Signature of Client, Parent or Legally Authorized Representative

Date

HEALTH PSYCHOLOGY ASSOCIATES

245 Mt. Rose Street

Reno, NV 89509

775-448-6828

F/775-322-2964

Consent for Services

1. I understand that the fee for each 50 minute therapy session is my responsibility.
2. I agree to give 24 hour notice if I am unable to make a scheduled appointment. I understand that I will be charged the usual fee for any appointment not cancelled 24 hours in advance. If you miss a session without cancelling, we will assume that you have terminated therapy unless you call within 30 days to reschedule.
3. I understand that every effort will be made to keep the information obtained from each session strictly confidential, as provided by law. Information concerning me will be released to outside this facility only to agencies or individuals specifically designated by me in writing.
4. The exceptions to this policy are: (1) when in the therapist's judgment I am determined to be dangerous to myself or others; (2) when in the therapist's judgment I am suspected of child or elder abuse or neglect; (3) when my client material is ordered to be released by the courts as an essential part of a legal proceeding; and (4) during court ordered treatment.
5. In the event there are two or more clients in therapy at the same time (e.g., couples therapy), I understand that no information about these sessions can be released without the written consent of both parties.
6. I agree to inform my therapist of any pending legal action initiated by me or legal action brought against me.
7. I understand that the purpose of therapy is for my enhanced psychological functioning and specifically not intended to be used in any current or future legal proceedings (e.g., custody, divorce, civil, or criminal proceedings).
8. I understand that no treatment will be provided to me when I am under the influence of alcohol or drugs.
9. I understand that terminating therapy is part of the therapy process. I agree to terminate therapy by way of discussion with my therapist, not by cancelling a therapy session.
10. I understand that my signature below indicates that I have read the information above and that I fully and freely give my consent.

Name of Client (Please Print)

Signature of Client (if over 18 years of age)

Date

Signature of Parent or Legally Authorized Representative

Date

Client Information Form

Please fill in the information below for each family member attending therapy. All this information is quite personal. Do not provide this information to anyone other than your therapist. Photo ID, insurance card, and co-pay are required on day of visit. If you did not bring your insurance card(s) with you, all charges will be your responsibility and payable at the time of service. All unpaid balances and denied claims are your responsibility. By signing this form you are consenting for you and your insurance to be billed.

Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review the notice before signing this consent. A copy is available upon request. As provided in the notice, the terms of the notice may change. If there are changes to the notice, you may obtain a revised copy by contacting, Natalie Sanchez, MFT with Health Psychology Associates, at 775-448-6828.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction but if we do, we are bound by our agreement. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures based on your prior consent.

(Client) Last Name: _____ First: _____ Middle Initial _____

Parent(s) Name if Client is under 18: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: M F

INSURANCE INFORMATION

Primary Insurance Name: _____

Insured's Name: _____ Insured's Date of Birth: _____

Policy ID#: _____ Group#: _____ Copay: _____

Secondary Insurance Name: _____

Insured's Name: _____ Insured's Date of Birth: _____

Policy ID#: _____ Group#: _____ Copay: _____

Client or Parent/Legal Representative Signature: _____

Print Name: _____ **Date:** _____