

Teresa M. Picciocchi, Psy. D.
Licensed Psychologist (PY7228)

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INFORMED CONSENT FOR EVALUATION AND TREATMENT

Patient's Name: _____

I, _____, hereby consent to evaluation and /or treatment of myself/my child rendered by Dr. Teresa M. Picciocchi. I agree that should I present my child for evaluation and/or treatment, that I have legal authority to do so. I understand that it is my responsibility to maintain scheduled appointments, provide payment for services rendered, provide an accurate and complete account of current and past evaluations, treatment, symptoms, and complaints, follow through on agreed upon recommendations and provide any information necessary for insurance billing.

Confidentiality Disclosure:

Communication between client and physician is considered confidential. However, I understand that the confidential nature of my records *may not be protected* under the following circumstances: Suspicion or evidence of child abuse or neglect; Immediate danger to myself or other; Need for hospitalization; In the event that it becomes necessary to submit charges to a collection agency for non-payment; Legal case in which I am a plaintiff seeking medical or psychological damages; Legal cases in which I use my psychiatric status as a defense or mitigating circumstance; and cases involving health professionals who may be impaired or violating licensing statutes or rules.

Release of Information to Insurance:

I understand that Dr. Picciocchi may or may not be under contract with my insurance carrier and may or may not be able to file insurance claims for me. I understand that if Dr. Picciocchi is unable to file claims with my insurance carrier, it is my responsibility to provide payment for the services rendered and personally submit claims to my insurance carrier for reimbursement. In the event that Dr. Picciocchi will be submitting claims to my insurance carrier, I hereby release any and all medical information to the insurance carrier necessary to process my claims. I reassign my benefits to Dr. Picciocchi, thus authorizing my insurance company to reimburse her directly for her services.

I understand that while mental health providers may substitute a summary of records, that insurance companies may still request the original record. In order to expedite claims, I authorize release of a copy of the original complete record to any requests for documentation by the insurance carrier or its representatives.

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By signing below, I indicate my understanding of the above, agreement to the above terms and conditions and that the above has been explained to me in terms that I understand. BY signing below I also indicate I have asked any questions I may have about the above terms and conditions and my questions have been answered. I agree to Evaluation and treatment and agree to the above terms and conditions and release of information.

Patient _____ Date _____

Parent or Guardian _____ Date _____