Center for Psychological Services

600 25th Avenue South; Suite 109
St. Cloud, MN 56301
Phone: 320.255.0343 Fax: 320.654.0318

CONSENT FORM

This form references the clinical relationship between:

______________________________ **AND**
Client

- ○ **Elizabeth Buhl, PsyD, LP**
- ○ **Lisa Jensen, MSW, LICSW**
- ○ **Julie Kieke, MA, LMFT**
- ○ **Lori Nelson, MSEd, LP**
- ○ **Gayle Neuerburg, MS, LMFT**
- ○ **Pamela Rieland, MS, LMFT**
- ○ **Julie Spare, MS, LP**
- ○ **Norma Taylor, PsyD, LP**
- ○ **Leslie Young, MS, LPCC, RPT**

For Minor Children or Clients Under Guardianship

I give consent for my minor child or ward to receive therapeutic services in my presence or in my absence.

Initial Here ______________

Release/Exchange/Assignment of Benefits

I consent to the release of information from the therapist to my insurance company, EAP, or managed care group to facilitate payment and continued coverage under the mental health benefit of my policy. I also consent to have the therapist and/or therapist's billing service submit claims and record payments on my behalf to/from myself, my insurance company, EAP, managed care, or other third party payer.

Initial Here ______________

Physician Release *(please indicate which option)*

O I do not wish to release information to/with a physician at this time
O I wish to have my physician notified that I am being seen by the above provider.
(A separate release form and complete contact information are required.)

Initial Here ______________

Informed Consent

I have review the "Informed Consent Form" and am aware that a printed copy is available upon request.

Initial Here ______________

Billing Policy

I have received AND reviewed the billing policy of Center for Psychological Services. I understand that my signature indicates that I am ultimately responsible for payment of all services rendered regardless of who the named policyholder is. I also understand that if my account becomes past due, a collection agency will be contacted.

Initial Here ______________

Consent for Consultation

The therapists at Center for Psychological Services meet regularly for clinical consultation. I am aware of this and give my consent for confidential clinical review of my case.

Initial Here ______________

Appointment Reminders

I would like to receive appointment reminders by text or email, please send to the following:

Phone number **OR** Email:____

Please note: It is your responsibility to keep us updated with your current phone and email information. We are not responsible for appointments missed due to failed text or email messages. Please keep track of your appointments.

______________________________________ ______________________________
Signature of Client or Parent/Guardian **Date**

______________________________________ ______________________________
Print Name of Client or Parent/Guardian **Relationship to Client**