Angela C. Stanley, Psy.D. Psychological Services, LLC
W178N9912 Rivercrest Drive, Suite 108
Germantown, WI 53022

Informed Consent for Mental Health Treatment

Client Name: ____ Date of Birth: ______________________

By signing this form, I acknowledge that I have received a copy of this practice's Notice of Privacy Practices, and specifically agree to the following:

1. I understand and give consent for the use and disclosure of my protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO). This includes disclosing my PHI and limited information about my diagnosis and care to third party payers, our billing service, Billing Specialist Services (BSS), and as needed, to other providers involved in my care.
2. I understand that Dr. Stanley and/or BSS may contact me by telephone, mail, email, or text as I have indicated on my history form for appointment reminders, communication about my care and billing/payment matters.
3. Billing statements will be sent via email. I agree to have my billing statements emailed to the following email address (Please Print Clearly):____
4. I understand that every effort is made to keep my PHI confidential. In addition to TPO described above, other disclosures of PHI may be required by law. These include but are not limited to:
    a. To government authorities, including the police or Child Protection Services, in cases of suspected abuse or neglect of minors or the elderly.
    b. To appropriate authorities or other persons to aid in prevention of an imminent threat to the safety of myself, another specific person, or the general public.
    c. To a court of law pursuant to a court order.
    d. Other situations as required by law, as detailed in the Notice of Privacy Practices.
5. Payment is expected at the time of service unless other arrangements are made in advance. I understand that standard collections procedures will be followed in the event of non-payment.
6. I understand that my session time is set aside specifically for me. A minimum 24-hour notice of cancellation is required to avoid being charged for the session. Without a 24-hour notice I will be charged the following fees at my therapist's discretion:
    a. 1st Late Cancellation/No Show = No Charge
    b. 2nd Late Cancellation/No Show = $100 Charge
    c. 3rd and Subsequent Late Cancellation/No Shows = $150 Charge
7. Treatment may be terminated in the event of excessive no shows, non-payment for services, refusal to follow treatment recommendations, or inappropriate/violent behavior. In the event of treatment termination, referrals to other providers for continued treatment will be provided.

I understand that I may revoke my consent in writing with the exception of disclosures that have already been made. If I do not sign this consent, or later revoke it, treatment may be denied or discontinued.

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Signature of Patient or Parent/Guardian Date

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Signature of Clinician Date