John W. Hall, PhD - Psychotherapy and Consultation

7th Street Psychotherapy, 1801 E 5th Street, Ste 210, Charlotte, NC 28204
[voice] 704.258.5553 [fax] 704.344.0078
john@drjohnhall.com

Personal Information		
Patient's Name		
Patient's Insurance ID #		
Patient's Date of Birth		
Patient's Address		
Patient's E-Mail		
Patient's Telephone		
OK to Leave Message?	Yes	No
Emergency Contact Name		
Emergency Contact Phone		
Patient's Employer or School		
Patient's Relation to Insured		
Insured's Name		
Insured's Date of Birth		
Insured's Address (if different)		
Insured's E-Mail		
Insured's Telephone		
OK to Leave Message?	Yes	No
Primary Care Physician (PCP)		
PCP's Telephone #		
Patient's Medical Problems & Medications		
Household Members		
Goal of Therapy		

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Informed Consent for Treatment

I have chosen to receive psychotherapy services from John W. Hall, PhD. My choice has been voluntary and I understand that I may terminate therapy at any time. I understand that I am being treated only by Dr. Hall and that other therapists present in 7th Street Psychotherapy are not participating in my treatment.

I understand that there is no assurance that the client will feel better, because psychotherapy is a cooperative effort between the client and the therapist. I understand that during the course of psychotherapy material may be discussed which will be upsetting in nature and that this may be necessary to help the client resolve his or her problems. I understand that I have a right to have my questions about treatment answered by Dr. Hall.

I attest that if the client is a minor or is otherwise dependent on me, I am the natural parent or legal guardian of the client, and therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned on this form.

I understand that confidentiality of records of information collected about the client will be held or released in accordance with state laws regarding confidentiality and according to the federal Health Insurance Portability and Accountability Act of 1996 (a copy of which as it pertains to this practice is available to me if I ask for it). In general, this means that information collected during therapy will be released only with my written consent. I further understand, however, that state law requires that Dr. Hall release information without my consent in conditions including, but not limited to the following:

- He has reason to believe that a child or dependent person is in danger.
- He has reason to believe that there is imminent danger to a specific person.
- He is ordered by a court of competent jurisdiction to release records.

I understand that I am responsible for any fee or copay at the time of service. I understand that if I fail to pay my balance for more than two appointments, I will no longer be eligible for services until my bill is paid in full. I understand that it is my responsibility to determine that insurance will pay for services before they are rendered, and that if they do not, I will be financially responsible for all services rendered. I also understand that any check returned by my bank will cause a $25 returned check fee to be added to my account. If it becomes necessary to use collection processes due to lack of payment for services, Dr. Hall will disclose as little confidential information as necessary for the purposes of collection.

I understand that if therapy is being paid for using insurance, Dr. Hall will release any and all records pertaining to treatment to the insurance company and to the primary care physician electronically or by mail if such disclosure is necessary for claims processing, case management, coordination of treatment, or utilization review purposes. I authorize insurance to pay Dr. Hall. I acknowledge that a copy of my Rights & Responsibilities as defined by my insurance carrier (if applicable) is available to me.

I understand that I need to attend all scheduled appointments. If I am unable to attend a scheduled appointment, I understand that I must let Dr. Hall know more than 24 hours in advance by leaving a voice-mail at 704.258.5553, or else I will be responsible for the full fee for the session ($150.00), which insurance will not pay. I further understand that if I am more than 15 minutes late for my scheduled appointment and have not let Dr. Hall know, my appointment will be canceled and I will still owe the same fee.

I understand that I may address any concerns or grievances with Dr. Hall or a representative of my insurance company at any time. I also understand that I can contact the North Carolina Psychology Board, which licenses psychologists, at 828.262.2258.

I understand that I can revoke this consent at any time, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in any benefit plan.

______________________________	______________________________
Patient's Signature	Date
______________________________	______________________________
Parent/Guardian's Signature	Witness's Signature