Stephens Psychological Services
Dr. Carol Stephens PsyD, LP, CBSM
drcarolsunvalley@gmail.com
208-928-4569

Informed Consent for Treatment and Release of Information

Name of Client:_____ Date of Birth_____

I have been informed that Dr. Stephens is not a Medicare or Medicaid Provider and that my care is my financial responsibility, and not to be submitted to Medicare.

I consent for SPS to provide psychological services, including but not limited to evaluations, follow up visits, and other psychological services. I have the right to ask for clarification about the treatment being provided and to terminate treatment if I so choose.

I authorize and consent to the release of my health records and medical information about me to/from the below named persons and providers who are being consulted about my care, or are providing care directly to me in connection with my current treatment.

_____
_____
_____
_____
_____

Signature of Client_____ Date _____

Authorized Family Member or Legal Representative:_____Date_____

Provider Signature_____ Date_____

PLEASE DOCUMENT ANY CONCERNS ABOUT CAPACITY TO COMPREHEND OR MAKE SAFE DECISIONS ABOUT HEALTHCARE