Elizabeth Shryer Boyle Psychological Services *1599 Selby Ave., Ste. 103, St. Paul, MN 55104*

Consent for Evaluation and Treatment

Mental Health Services: This statement endorses that you give your permission to ESB Psychological Services to evaluate your condition, administer any diagnostic testing, develop a treatment plan based on your diagnosis, and provide you with treatment, with your participation. Your signature states that you understand that the practice of psychotherapy, along with possible medication, is not an exact science and that there are no guarantees about results of treatment in this clinic.

After Hours Emergency: This clinic is not open 24 hours and has no on-call service. If an emergency arises, you will be directed to follow any developed safety plan, to call 911, or go to the nearest emergency room. Your signature below indicates that you are aware of this policy.

Privacy Policy and Client Rights and Responsibilities are fully explained on another form. That form also explains how to handle any complaints, grievances, and how records are managed. Please note that email is not a confidential method of communication, as our site is unable to be encrypted to protect your privacy. Your signature below endorses that you received a copy of our Privacy Policy and Client Rights and Responsibilities and have been informed of our policies.

Confidentiality: Your diagnosis and type of session will be shared with a billing service; no clinical information will be shared. In the event that we need to reach you or send something by U.S. mail, please advise us below how best to preserve your confidentiality. Unless otherwise directed, we will call your preferred number, ask for you, and leave the doctor's name. Let us know if it is acceptable to also leave additional information, and if it is acceptable to use your mailing address.

Guarantee of Account: You are agreeing to: pay Elizabeth Shryer Boyle Psychological Services for all charges not covered by any third party payer (insurance); be responsible for obtaining and following the rules of my insurance company; obtain prior authorization when needed; accept responsibility for payment of unauthorized visits; consent that payment for services of authorized benefits will be paid directly to the clinic; pay all bills and fees as agreed upon promptly or incur additional fees.

Consent for release of information. You are agreeing to: provide all necessary information to third party payers to process claims for care; revoke this authorization in writing if desired, knowing that no more records may be released rom the date forward from when I sign that request; and that I understand that if I choose to revoke consent to release information, it may change my psychologist's ability to continue providing services, especially if it is to an insurance company, or if the psychologist deems it to be in my best interest.

This consent expires one year from date of signature or as otherwise indicated.
I have read these policies and understand the contents. Please contact me as shown below:

Patient Printed Name _____

Patient Signature_____ Date: _____
Parent/Guardian Signature _____ Date: _____

Telephone # 1 _____ Address: _____
Telephone # 2_____ OK to send mail there? _____

July 1, 2014