Portal
Psychological Services

Inform Consent

According to existing laws (HIPAA) the nature and purpose of the proposal assessment/evaluation and / or treatment which may include psychological testing, psychotherapy, alternative therapies or other forms of treatment including the alternative of no therapy have been discussed with me and I understand the risks involved. Therefore I consent to my treatment or any of my family. Consequently I authorize the following procedures for my welfare and my relatives (children, or others). I certify that I have received the rules and regulations of HIPAA

I understand the terms and conditions as well as the rules and policies of this office I agree to abide by them. I authorize Dr. Portal to:

_____Perform a psychological evaluation, mental examination, counseling and / or psychotherapy

_____Report to authorities if I'm going to commit a crime hurt others or going to kill myself.

_____Report authorities if there is a suspicion of child abuse or elderly.

_____Charge me for services if my insurance company does not cover the costs of the services I need. Charge for no shows if I do not provide a notice directly by phone before 24 hours. E-Mails contacts are no valid

_____Contact my insurance company for benefits and payments

_____Terminate my treatment if I do not follow the goals, guidelines and objectives of my treatment plan ; not following the rules and policies of the office.

_____Contact my previous doctor or doctors to coordinate activities with my treatment.

_____Contact my spiritual advisor, pastor or priest to coordinate activities for my treatment.

_____ Accept consultation from the Emergency Room (ER) in case of emergency and the ER staff is asking for Information to save my life.

_____Terminate treatment if the demands for compliance are not met, missing two sessions without notice of cancelation 24 hours before the appointment or decide to sue my therapist or designee

_____Terminate treatment if your behavior is violent, making threats or come to sessions under the influence of Illegal substances including alcohol, abuse or misuse psychotropic medications. Coming to session with firearms or other lethal weapon.

_____Disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose health information to authorized federal officials if required for lawful intelligence, or order national security activities.

I certify that I have read it, understood and agree to the above statements and that I have received a copy of this document.

Client's / Responsible Name_____ DOB:_____

Client's / Responsible Signature _____Date:_____