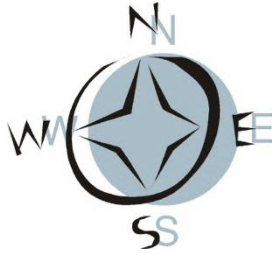

Compass Psychological Associates

Providing Direction and Hope for Children and Families

Serving the North Central Texas Region

Phone: (214) 824-8878 • EFax: (214) 291-5949
E-Mail: referrals@compasspsych.com

AUTHORIZATION FOR PSYCHOLOGICAL ASSESSMENT SERVICES
AND RELEASE OF CONFIDENTIAL INFORMATION

PATIENT NAME: ____ **DATE OF BIRTH:** ________________

Medicaid/ SSN #: __________-___________-___________

Confidentiality and Release of Information: All records and health information collected will be kept confidential in compliance with the State and Federal Regulations of the Health Insurance Portability and Accountability Act and in accordance with other applicable state and federal regulations regarding the confidentiality of such records and information. Private health information and records will be released regardless of consent under the following circumstances:

1) All cases of physical and sexual abuse or neglect of a minor will be reported to law enforcement or other appropriate agency.
2) All cases in which there is a danger to self or others will be reported to law enforcement or other appropriate agency.
3) If a patient is in need of emergency services, appropriate emergency personnel will be contacted.
4) All records subpoenaed by a Court will be released.

Insurance Authorization: I request that payment of authorized insurance benefits be paid to Compass Psychological Associates on my behalf for any services rendered to me. I authorize Compass Psychological Associates to release to Medicaid or any other third party payer, state medical assistance agency, or any other payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original**.**

Treatment of Minors: Treatment of minors under the age of 18 will only be provided with permission of the legal guardian (as established by the state or divorce decree). By signing this form, the guardian acknowledges that he or she is the patient's legal guardian or an authorized representative of the legal guardian.

Cancellation Policy: Please notify the Compass office of a cancellation as soon as possible. A missed appointment without a minimum of 24 hours advanced notice will be charged to the appropriate responsible party at the standard rate or at a lesser rate solely at the discretion of Compass Psychological Associates.

Informed Consent: I hereby authorize Compass Psychological Associates to provide psychological assessment for the above name individual. By signing this treatment agreement, the guardian acknowledges that he or she has had the above information explained and translated. Your signature below indicates authorization for services to be provided by Compass Psychological Associates in accordance with the above.

Release of Information: I hereby give permission for psychological information obtained by Compass Psychological Associates to be released to my physician, Child Protective Services, my foster care agency, and/or other health care facilities as is necessary for follow up and continuity of care. Copies of reports are to be utilized by professional personnel only. Any information released to others will require interpretation. In addition, guardian acknowledges that he or she has received a copy of Compass' Notice of Privacy Practices and has read and understands such practices.

____
Signature of Patient, Guardian, or Other Person Authorized
to Obtain Psychological Services

____
Date _______/ _______/ ________

Phone Number: ______-_______-__________

____
Relationship____

3710 Rawlins • # 1370 • Dallas, Texas 75219 ~ Website: www.compasspsych.com