DOCUMENTATION OF RECEIPT OF NOTICE
AND PERMISSION FOR EVALUATION AND/OR TREATMENT

I acknowledge that I have received a copy and/or had the opportunity to review the NORTH CAROLINA NOTICE FORM that explains policies and procedures to protect the privacy of my health information.

I acknowledge that I have received a copy and/or had the opportunity to review Dr. Stallings' business policy of Triangle Psychoeducational Consultants, PLLC and agree to its terms.

I give my permission for consultation, evaluation, and/or treatment with Dr. Stallings.

_____ _____

Signature of Patient (if Patient Age is 18 or Older) or Signature of Parent or Legal Guardian of Patient **Patient Full Name**

_____ _____

Date **Patient Date of Birth**

_____

Signature of Person Responsible for Account Balance / Address if Different From Patient Address

In an effort to help patients manage their account balances effectively and efficiently, we ask that you provide a MasterCard or Visa number to be applied to any outstanding account balances. You will be notified any time your credit card is applied to your account balance.

Card number and expiration date: _____

Patient Parent/Guardian: Name_____ Age_____ Education_____

Occupation_____ Employer _____

Patient Parent/Guardian: Name_____ Age _____ Education_____

Occupation _____ Employer_____

Please indicate what means I have your permission to communicate with you and/or to send information related to your/your child's mental health information to you:

1) US Mail **(Provide address**):

2) Home phone / voice mail (**Provide number**):

3) Business phone / voice mail (**Provide number**):

4) Cell phone / voice mail (**Provide number**):

5) Electronic mail **(Provide e-mail address**):

**CAUTION IN REGARD TO E-MAIL: Unencrypted, unauthenticated Internet e-mail is inherently insecure. Internet messages may be corrupted or incomplete, or may incorrectly identify the sender. Complete confidentiality cannot be guaranteed if you communicate with me via e-mail.