MARK S. RIDER, PH.D, LICENSED PSYCHOLOGIST

325 MIRON, SUITE 150, SOUTHLAKE, TX 76092
PHONE/FAX 817-442-1707

INFORMATION AND TREATMENT CONSENT FORM

Name_____SSN_____

Birthdate_____Insurance Co_____

Name and SSN of Insured (if different)_____

Street Address_____

City/State/Zip_____

Phones(H)_____(W)_____(Cell)_____

Medications_____

Complaints/Symptoms_____

Psychiatrist/PCP_____

Statement of Understanding

I hereby consent to the administration of psychological services for (check line):
Myself_____ My Dependent_____

I hereby authorize medical benefits to be paid to Dr. Rider and confirm that I am not covered under any other insurance plan, which would also cover any of these treatment expenses.

I understand that all information disclosed is confidential except 1) to communicate with my PCP (or psychiatrist) and insurance company about my case, 2) if imminent danger exists to myself or others, and 3) if a child's welfare is threatened.

I understand that I am responsible for any treatment costs which are not reimbursed by my insurance company, EAP, or hospital.

I understand that I am financially responsible for any session cancelled within 24 hours, except for emergencies.

_____ _____
Signature of Patient or Guardian Date