Intentional Aging
Dr. Carol Stephens Psy D., LP, CBSM
drcarolsunvalley@gmail.com
612-251-7413

Informed Consent, Release of Information Authorization, Non-Medicare Provider Agreement

Name of Client:_____ Date of Birth:_____

I have been informed that Dr. Carol Stephens is **not an approved Medicare provider** and may not submit bills for my care to Medicare. I agree to pay Dr Stephens directly for services.

Initial_____

I consent for Dr Stephens to provide psychological services, including but not limited to evaluations, follow up visits, and other care management services deemed necessary for optimal care. I have the right to ask for clarification about the treatment being provided and to terminate treatment if I so choose.

Initial_____

I authorize and consent to request for, and release of, my health records and medical information to named providers being consulted about my care, or are providing care directly to me in connection with my current treatment. I also consent to release of information to family members and caregivers identified below for continuity of care

Initial_____

Release of information approved for the following people on my care team

_____

_____

_____

_____

_____

Signature of Client_____ Date_____
Authorized Family Member /Legal Representative:_____
Date_____
Signature of Provider _____Date_____

If there are concerns about the patients capacity to manage his/her own care please submit additional information. Thank you