Print Patient Name____

CONSENT TO CONTACT: In accordance with the HIPPA Privacy Rule, we cannot contact the patient; leave a voicemail or a message with someone without the patient's consent. We cannot leave a message at a place of employment.

Please check ONE of the following statements to indicate your preference for contact.

☐ **You MAY NOT contact me** by phone and/or leave a message for appointment reminders or to notify me of a doctor/therapist cancellation. I understand that I am responsible for keeping my appointments and I understand that a missed appointment fee will be charged for appointments cancelled less than 24 hours in advance.

☐ **You MAY contact me** by phone and/or leave a message for appointment reminders or to notify me of a doctor/therapist cancellation at the following phone number(s)

Preferred contact: ☐ cell ☐ home ___ ___ ___-___ ___ ___-___ ___ ___ ___
Alternate contact: ☐ cell ☐ home ___ ___ ___-___ ___ ___-___ ___ ___ ___

Please note: For reminder calls we will only call your preferred contact#. In the event we need to cancel your appointment or reach you for any reason we will call the preferred and alternate contact #'s provided.

________________________________ ____________ ____________________

Signature of Patient (Or Responsible Party if Patient is a Minor) **Date** **Relationship to patient**

RELEASE FOR COORDINATION WITH PRIMARY CARE PHYSICIAN

CHECK ONE: **YES, I DO**____ **NO, I DO NOT**____ give permission to Chesapeake Psychological Associates to release information about my current treatment to my primary care physician.

If you checked YES, please complete the following:

Primary Care or other Physcian Name____

Address____

Phone (____)_____-__________ Fax (____)_____-__________

PATIENT SIGNATURE (parent if minor): ________________________ Date: ________