DFW Psychological and Consulting Services, Inc.

Name (Please Print)_____

Street address _____

City _____ State_____ Zip_____

Home#: _____Cell: _____ Other _____

I am being seen by Dr. Eitel's office for the following purpose **and**
I agree to the following procedure: (Check one)

_☐ Individual, marital, or family psychotherapy

_☐ Group psychotherapy

_☐ A psychological evaluation for Department of Assistive & Rehabilitative Services (DARS) (clinical interview, academic test, intellectual test, personality test)

_☐ A psychological evaluation for Disability Determination Services (Social Security) (clinical interview and may include cognitive testing)

_☐ Evaluation_____

I have been given a notice form that describes the privacy policies for my protected health information.

_____ _____
Signature Date

Request for Confidential Communication of Your Protected Health Information

Please circle your response the following:

May we leave messages concerning your **appointments** with a coworker, receptionist, or secretary that regularly answers your calls? ☐Yes ☐No ☐N/A

May we leave **messages** on a voice mail at work? ☐Yes ☐No ☐N/A

May we discuss your **appointments/treatment** with your spouse or other person (Insert name) _____? ☐Yes ☐No ☐N/A

If you are over the age of 18, still living at home, may we discuss your **appointments or treatment** with your parent(s)/guardian(s)? ☐Yes ☐No ☐N/A

If you are over the age of 18, may we discuss your **appointments/treatment** with your children? ☐Yes ☐No ☐N/A

You must inform us **in writing** if you wish to change the manner in which this office communicates with you. Thank you.