

Lake Norman Psychological Services, PLLC

Jennifer Sadoff, Ph.D.
9820 Northcross Center Court
Huntersville, NC 28078
(704) 677-2652

Patient Name: _____

Date of Birth: _____

SERVICES AGREEMENT

Your signature below indicates that you have read the “**PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT**” and agree to its terms, and have been offered a copy of “**NOTICE OF PSYCHOLOGISTS’ POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION**”:

Signature of patient or patient’s legal representative

Date

Print Name

Relationship to Patient (if applicable)

PAYOR AUTHORIZATION

I authorize my psychologist, Jennifer Sadoff, Ph.D., or her administrative staff, to release the minimum necessary medical information in written, oral, or electronic format required for filing a payable insurance claim. I also authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

Signature of patient or patient’s legal representative

Date

Print Name

Relationship to Patient (if applicable)

CONSUMER RIGHTS (MEDICAID)

I have received a copy of “**YOUR RIGHTS AND RESPONSIBILITIES,**” and understand and agree to its terms.

Signature of patient or patient’s legal representative

Date

Print Name

Relationship to Patient (if applicable)