Sharon M. Parkinson, Psy.D.

1205 Piper Blvd., Suite 203, Naples, FL 34110
Phone: 239-777-2387 Cell: 239-370-1188 Fax: 866-583-8113

Patient Registration Form

Referring Physician: _____ Primary Care Physician: _____
Last Name: _____ First Name: _____ MI: ___
DOB: _____ Gender: M or F SSN#: _____Marital Status: _____
Local address: _____City/State:_____ Zip:____
Alternate address: _____City/State: _____ Zip:____

Automated appointment reminders are sent out. Please specify how you would like to be reminded of appointments or contacted?

Home phone: _____ Cell/text: _____carrier: _____ Work phone: _____

E-mail address: _____

Insurance Information

Primary Insurance Name: _____
Insurance Address: _____City/State: _____ Zip:____
Subscriber Name: _____ DOB: _____ Relationship to Patient: _____
ID#: _____ Group#: _____

Secondary Insurance Name: _____
Insurance Address: _____City/State: _____ Zip:____
Subscriber Name: _____ DOB: _____ Relationship to Patient: _____
ID#: _____ Group#: _____

Sharon M. Parkinson, Psy.D.

1205 Piper Blvd., Suite 203, Naples, FL 34110
Phone: 239-777-2387 Cell: 239-370-1188 Fax: 866-583-8113

Authorization for Use and Disclosure of Protected Health Information

Name: _____
SS#: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: _____ May we leave a message? Y N

I _____ do hereby authorize disclosure or exchange of above named individual's health information by Sharon M. Parkinson, Psy.D.

The type of information to be disclosed or exchanged is as follows:

_____ Intake Summary
_____ Termination Summary
_____ History and Physical
_____Discharge Summary
_____Lab Reports (CT, MRI, etc.)
_____ Other _____
_____ Office Notes
_____ Psychological Treatment Summary
_____ Therapy Notes
_____ Results of psychoeducational testing
_____ Verbal exchanges of information

The information can be disclosed to the following persons or organization:

Name: _____Address: _____
Telephone and Fax: _____

Name: _____Address: _____
Telephone and Fax: _____

Name: _____Address: _____
Telephone and Fax: _____

I understand that I may revoke this authorization at any time and my revocation must be delivered in Writing and will be effective at the time of receipt. I understand that this revocation will not apply to Information already released according to this authorization.

This Authorization is in effect from _____ to _____

_____ _____
Signature of patient or legal representative Printed name of patient or representative

_____ _____
Date Relationship to patient (if applicable)

Sharon M. Parkinson, Psy.D.

1205 Piper Blvd., Suite 203, Naples, FL 34110
Phone: 239-777-2387 Cell: 239-370-1188 Fax: 866-583-8113

Consent for Psychological Evaluation

I understand that the purpose of this evaluation is to provide information about me for my physician or other provider who has requested the evaluation to assist in their treatment of me or to determine the need for service. The information from the interview and testing will result in the generation of a report that will be sent to the referring provider and Dr. Parkinson may disclose information important in my care. If I desire, I can have this information disclosed to others, which I designate by signing an authorization to release PHI. If this evaluation is covered by a third party payer (i.e., insurance), Dr. Parkinson may be required to provide the insurance company with the report, as well.

There are a few situations in which a healthcare provider is required to provide information without a release:

- If there is clear and immediate probability of physical harm to the client, to other individuals, or to society, information may be disclosed to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or seeking hospitalization of the client.

- If there is knowledge or reason to suspect that a child under 18 is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires the health care provider to file a report with the Department of Children and Families. Once such a report is filed, the therapist may be required to provide additional information.

- If there is knowledge or reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited, the law requires that us to file a report with the Department of Children and Families. Once such a report is filed, the provider may be required to provide additional information.

I guarantee prompt payment of all charges incurred for services rendered but not covered by insurance. Payment will be made of any balance within 30 days of billing.

NO SHOW POLICY: A 24 hour notice is required for any appointment change or cancellation. I understand that the schedule has limited availability, therefore, it is important that I notify the office as soon as possible so that others can be seen. If a 24-hour notice is not given, I agree to pay a charge of $50, which must be paid prior to my next visit. I acknowledge that I am responsible for this amount, and that my insurance carrier will not cover it.

Sign: _____ Date: _____
Printed Name: _____

Guardian: _____