PARKER COLLINS
FAMILY MENTAL HEALTH

1056 Centerville Circle | Vadnais Heights, MN 55127
Phone 651.604.7771 | Fax 651.426.8116

Client name:		Client DOB:	

OUTPATIENT SERVICE CONTRACT
Your signature below indicates you have read and understand the Outpatient Service Contract. Your signature indicates agreement with this document, the terms and policies contained therein, and an acknowledgement that you have been offered a copy of this document.

FINANCIAL POLICY
Your signature below indicates that you have read the Financial Policy. Your signature indicates agreement with this policy and an acknowledgement that you have been offered a copy of this document.

NOTICE OF PRIVACY PRACTICES/HIPAA
Your signature below indicates you have read and understand the Notice of Privacy Practices document. Your signature also serves as an acknowledgement that you have been informed of your privacy rights, our responsibilities, and have been offered a copy of this document.

SOCIAL MEDIA POLICY
Your signature below indicates that you have read the Social Media Policy and understand your rights. Please indicate below your texting preference:
I authorized use of electronic messaging for the following:

☐ Automatic appointment reminders ☐ Direct contact with therapists or staff

☐ I do **not** authorize the use of text messaging for any reason

Release to Primary Care Physician (leave blank if client signs ROI)
If client is not authorizing release for Parker Collins to communicate with client's primary care physician, please indicate one of the following:

☐ Client does not have a primary care physician at this time.
☐ Client has a primary care physician but does not want to sign a release of information at this time.

These forms have been explained to me, and I have been given an opportunity to ask questions about them. I understand that I may revoke my consent at any time with written notice.

X _____ _____
Signature of Patient/Client, Parent, Guardian or Personal Representative **Date**

If signed by a personal representative, relationship to patient: _____

Rev. 3/2016