Please complete and sign these documents and either bring this packet to your psychological evaluation or email it to hpanevada@gmail.com. You can type right into this document.

The online questionnaire needs to be completed before your psychological evaluation appointment. It will take 25-30 minutes to complete the required online questionnaire.

Thank you for your participation.

Dr. Shoenberger

G D SHOENBERGER INC.
Deacon Shoenberger, Ph.D., LADC
Matthew Boland, Ph.D.
Georgia Dalto, Ph.D.
Suzanne Calzada, MFT
Dominique Cheung, M.A.

Consent for Psychological Evaluation

---

1. I understand that the fee for psychological evaluation is my responsibility.

2. I agree to give 24 hour notice if I am unable to make a scheduled appointment. I understand that I will be charged the usual fee for any appointment not cancelled 24 hours in advance.

3. I understand that every effort will be made to keep the information obtained from this evaluation therapy strictly confidential, as provided by law. Information gathered in this evaluation relevant to my medical treatment will be shared with my provider at Sasse Surgical Associates. Otherwise, information concerning me will be released to outside this facility only to agencies or individuals specifically designated by me in writing. The exceptions to this policy are: (1) when in the evaluator's judgment I am determined to be dangerous to myself or others; (2) when in the evaluator's judgment I am suspected of child or elder abuse or neglect; (3) when my client material is ordered to be released by the courts as an essential part of a legal proceeding; and (4) during court ordered treatment.

4. I agree to inform the evaluator of any pending legal action initiated by me or legal action brought against me. I understand that the purpose of this evaluation is for the stated purpose (e.g. appropriateness for gastric bypass surgery) and specifically not intended to be used in any current or future legal proceedings (e.g., custody, divorce, civil, or criminal proceedings) unless previously agreed upon.

5. I understand that my evaluation will be terminated if I am under the influence of alcohol or drugs.

6. I understand that my signature below indicates that I have read the information above and that I fully and freely give my consent. If I have any questions or concerns I may contact Dr. Shoenberger at 775-448-6828.

_____
Name of Client (Please Print)

_____ _____
Signature of Client Date

_____ _____
Signature of Legally Authorized Representative Date

G D SHOENBERGER INC.

245 Mt. Rose Street
Reno, NV 89509

Phone: (775) 448-6828
Fax: (775) 322-2964

Psychological Evaluation for Gastric Bypass/Lap Band Surgery

I understand that G D Shoenberger Inc. bills my insurance as a courtesy to me. I understand that I am responsible for authorizations, co-pays, deductibles and all remaining charges for services not covered by insurance. I understand that it is my responsibility to follow-up with my insurance carrier when a payment has not been made to G D Shoenberger Inc. I understand there is a $25.00 charge for returned checks and a $25.00 charge if my account is turned over to a collection service.

_____
Client's Name (Please Print)

_____ _____
Client's Signature (Parent/Guardian) Date

Client Information Form

Please fill in the information below for each family member attending therapy. All this information is quite personal. Do not provide this information to anyone other than your therapist. Photo ID, insurance card, and co-pay are required on day of visit. If you did not bring your insurance card(s) with you, all charges will be your responsibility and payable at the time of service. All unpaid balances and denied claims are your responsibility. By signing this form you are consenting for you and your insurance to be billed.

Notice of Privacy Practices provides information about how I may use and disclose protected health information about you. You have the right to review the notice before signing this consent. A copy is available upon request. As provided in the notice, the terms of the notice may change. If there are changes to the notice, you may obtain a revised copy by contacting me, Deacon Shoenberger, Ph.D. at 775-448-6828.

You have the right to request that I restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. I am not required to agree to this restriction but if I do, I am bound by our agreement. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures based on your prior consent.

Last Name: _____ First: _____ Middle Initial ____

Date of Birth: _____ Age: _____ Sex**:** M F SS# _____

Address: _____

City: _____ State:_____ Zip Code:_____

Home Phone #: _____ Cell Phone #: _____

INSURANCE INFORMATION (Please allow staff to photocopy your insurance and ID cards)

Primary Insurance: _____

Insured's Name: _____ Insured's Date of Birth: _____

Policy ID#: _____ Group#: _____ Copay: _____

Secondary Insurance: _____

Insured's Name: _____ Insured's Date of Birth: _____

Policy ID#: _____ Group#: _____ Copay: _____

Client or Guardian Signature: _____

Print Name: _____

Date: _____