Allyson Carlson Psy.D.
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Wading River, New York, 11792
631.708.5945

Patient Information Form

Name: Date: _____
Address: _____City: _____
Zip Code: _____

Home Phone: _____ Cell Phone :_____

Patient's Age:_____ Date of Birth:_____

Email address: _____

Emergency Contact Person:_____
Relationship of Contact Person: _____ Phone: _____

I do hereby seek and consent to take part in the treatment by Dr. Carlson. I understand that developing a treatment plan with Dr. Carlson and regularly reviewing our work toward meeting the treatment goals are in my or my child's best interest. I agree to play an active role in this process. I understand that no promises have been made to the results of treatment or any procedures provided by Dr. Carlson. I am aware that I may stop my treatment with Dr. Carlson at any time. The only thing I will still be responsible for is paying for the services that I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. I know that I must call to cancel an appointment at least 48 hours (2 days) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that Dr. Carlson is not responsible for my insurance carrier's decisions concerning claims and that if payment for the services I receive here is not made, Dr. Carlson may stop treatment. I have received and read the notice of privacy practices. By signing below, I am giving consent for treatment and/or evaluation, if necessary, of myself and/or my child as discussed with Dr. Carlson.

Signature: _____ Date:_____