**HAMPTON PSYCH NPS, PLLC CONSENT TO TREAT FORM**

I -------------------------------------------------------------------------(Name), hereby give permission for any and all mental health attention to the above private practice in good conscience to help me in my mental wellness/mental health. I assume responsibility for the payment of such treatment for all fees not sponsored by my insurance company effective date signed, until such a time that I no longer need the services from the above practice. I also promise to attend all scheduled appointments via telehealth [**https://doxy.me/psychnpnanaw**](https://doxy.me/psychnpnanaw)**, and make payments/co-payments via www.hamptonpsychnp.com**

Name:

Allergies:

Home Phone:

Work Phone:

Cell Phone:

Address:

Insurance Company:

Insurance Policy Number:

Primary Care Physician:

Phone # for PCP:

Address for PCP:

Emergency Contact Information and phone numbers:

1.

2.

3.

Patient or Parent Signature and Date:

