Consent for Services

By signing below, I consent to receive professional services from Dr. Michael Lax, PSY.D. I understand that I, or Dr. Lax may terminate these services if either one of us believe they are not helpful or needed. I authorize Dr. Lax (or his designee) to contact me at the numbers and/or postal and email addresses noted in the intake form as needed for scheduling, billing and other purposes (recognizing that email and voice mail communications may not be totally confidential from others).

I also understand that Dr. Lax is in solo practice and as such may not always be available to return calls immediately. Consequently, I agree that if I cannot reach Dr. Lax in a life threatening emergency I will get help from the police, 911 or my local emergency room.

I also agree to pay promptly and in full for services rendered (recognizing that Dr. Lax fees may increase over time) and for appointments that I do not cancel with at least 24 hours notice. I understand that upon request, and if appropriate, I can be given billing statements that I (or Dr. Lax's billing service) may submit to my insurance carrier.

By signing this form I acknowledge receipt of a copy of Dr. Lax's HIPAA policies notice.

Also, in signing this form, I acknowledge that I will not be seeking Dr. Lax's testimony in court or the similar use of his records.

_____ _____

Signature Date

_____

Print Name