# Notice to TRICARE Clients

TRICARE does not provide reimbursement for the following services. Therefore, we need to ask you to accept responsibility for payment should you incur fees for any of the following services.

- Telephone consultations
- Extended sessions
- No shows
- Late cancellations, or
- Travel

☐ By checking here, I agree that I personally will be responsible for the fees for any of these services, if incurred.

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It may be beneficial for us to confer with your primary care physician about your psychological treatment or to discuss any medical problems for which you are receiving treatment. TRICARE requires that we notify your physician by telephone, or in writing, concerning services that we are providing ***unless your request that we not make such notification***.

Please check one of the following:

☐ You are authorized to contact my primary care physician whose name is shown below to discuss the treatment that I am receiving while under your care and to obtain information concerning any medical diagnosis and treatment.

☐ I do not authorize you to contact my primary care physician in regard to the treatment that I am receiving while under your care or to obtain information concerning my medical diagnoses and treatment. I am providing you with the name of my primary care physician only for your records.

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Name, Address and Phone Number of Primary Care Physician ____________________________

______________________________________________________________________

_____________________________________________________
Print Client Name

____________________________________________________ _________________________
Client Signature Date

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