Heather A. Hopper, Ph.D.
Licensed Psychologist
Continuing Care Agreement 2025

Dr. Heather Hopper has made no changes to the Informed Consent form, fee schedule, HIPAA form, or telehealth or payment policies.

Consent to treatment

Your signature below indicates that you continue to agree to the information as laid out in the current informed consent and any addenda in your file. You are welcome to request a copy for your records.

_____

Printed Name Signature Date

HIPAA acknowledgement:

I acknowledge that I have had an opportunity to review the notice of Privacy Practices (HIPAA policies form) for Heather Hopper, Ph.D., located online at www.hopperpsychology.com.

_____

Printed Name Signature Date

Consent for Third Party Reimbursement (i.e. insurance, family member, etc):

I give permission for Dr. Hopper and her assigned representative to provide all information required for third party reimbursement. This may include dates and times of services, diagnosis, payment information, charges, clinical notes, communication records, etc. It does not include psychotherapy notes. I may revoke this permission at any time. However, I understand that without this permission, a third party may not be communicated with for the purpose of billing, and I accept all responsibility for charges made. The third party I permit communication with for reimbursement is:

_____.

It is my responsibility to inform Dr. Hopper if this information changes.

_____

Printed Name Signature Date

Current Contact Information (please re-enter in full)

Address _____

Preferred Phone _____

Email Address _____ (must have agreed to email conditions set forth in informed consent form)

Emergency Contact Person & phone _____