Mark R. Dell, Psy.D, L.L.C.
21 NJ-31, Suite A6A
Pennington, NJ 08534
(609) 439-6526

FAMILY SUPPORT SERVICES — REGISTRATION & CONSENT

Date of Registration: _____

I. CLIENT INFORMATION (parent / family member)

Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____

Second Family Member Attending: _____ Relationship: _____

Phone: _____

II. CONSULTATION FOCUS

Family member of concern (relationship and age only): _____

Is he aware this consultation has been scheduled? ☐ Yes ☐ No ☐ Unsure

III. SCOPE OF SERVICE

This is a professional consultation provided to you as the client. It is not psychotherapy, and it is not a clinical evaluation, diagnosis, or treatment of the family member being discussed.

The family member is not present and will not be interviewed, observed, or examined as part of this service. All findings and recommendations are based on the information you provide. No professional treatment relationship is established between this provider and the family member discussed.

☐ I understand and accept this scope of service.

IV. FEES

Consultation rate: $270.00 per hour, prorated for partial hours.

Consultations typically run 60–90 minutes.

Includes a written summary of findings and recommendations.

Payment is due upon completion of service. Private pay only; not billed to insurance.

Cancellation: 24-hour notice is required. Cancellations with less than 24-hour notice, or missed appointments, are charged $270.00.

☐ I understand the fee and cancellation policy.

V. CONFIDENTIALITY

This consultation is confidential and protected under HIPAA and applicable New Jersey law. Confidentiality may be limited where disclosure is required by law, including situations involving imminent risk of serious harm to any person, suspected abuse or neglect of a minor, elder, or dependent adult, or court order.

☐ I understand the limits of confidentiality.

VI. NOT AN EMERGENCY SERVICE

This consultation does not provide crisis management. If the family member discussed is at imminent risk of harm to himself or others, contact 988 (Suicide & Crisis Lifeline) or 911, or proceed to the nearest emergency department.

☐ I understand this service does not provide emergency or crisis care.

VII. AUTHORIZATION

☐ I authorize the maintenance and retention of records of this consultation.
☐ I authorize release of the written summary to: _____
☐ I do not authorize release to any third party without additional written consent.

Client Signature: _____ Date: _____
Printed Name: _____

Second Family Member Signature: _____ Date: _____
Printed Name: _____

Provider: Mark R. Dell, Psy.D. NJ License #: 35SI00480700 NPI #: 1053635409