CONSENT TO TREATMENT

Today's Date: _____

Client's Name: _____

Client Identification Number: _____

1. Consent to Treatment. I, the undersigned, hereby grant authority to Healing & Wellness Counseling, LLC (the "Company"), and it employees or contracted staff to provide me with the treatment as requested by me and ordered by my physician when applicable.

I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the client. If the patient is under the age of nineteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

2. Acceptance for Admission. I acknowledge I have been accepted for treatment with the Company and that Company has the ability to provide services at its location and other locations if requested. I acknowledge I will participate in developing my plan of care. I authorize Company to provide or arrange to provide the counseling services it deems necessary.

3. Acknowledgements.

a. Acknowledgment of Benefits and Risks. I have discussed the following with my counselor and I understand: (1) the nature, risks, benefits, and potential complications associated with my treatment; (2) reasonable alternatives to the proposed treatment and the risks and benefits of the alternative, including the results of not receiving a treatment; and (3) the limitations on the confidentiality of my health information.

b. Acknowledgment of Receipt of the Company's Notice of Privacy Practices. I have been given a copy of the Company's Notice of Privacy Practices for Protected Health Information. I understand the Company has the right to change the Notice of Privacy Practices at any time. I may obtain a current copy at the Company's office. The undersigned does hereby acknowledge receipt of the Company's Notice of Privacy Practices for Protected Health Information.

I give my consent for the use or disclosure of mine or my child's protected health information (PHI)* by the staff of the Company for the purpose of treatment, payment, and healthcare operations. I understand that if I do not sign this consent form agreeing to what is in the Notice of Privacy Practices, the Company cannot treat me and/or my child (ren).

I have a right to request (in writing) a restriction of how my PHI is used or disclosed to carry out treatment,

payment, or healthcare operations. the Company is not required to agree to the restrictions that I may request. However, if the Company agrees to a restriction that I request, the restriction is binding on the Company. Additionally, I understand that I have the right to revoke this consent, in writing, at any time.

*My PHI means health information, including demographic information, collected from me and created or received by my physician or health plan. This PHI relates to my past, present or future physical or mental health or condition and identifies me or my child.

4. Authorization to Pay Insurance Benefits: I hereby authorize payment directly to the Company for counseling and basic benefits payable to me, including Medicare and Medicaid, but not to exceed the regular charge for this period of service. I understand that I am financially responsible for charges not covered by this authorization.

To the best of Company's understanding, your _____ should cover _____ (Estimated Amount) of these charges. Estimated client responsibility: _____ (Dollar Amount/% Coverage). (See Explanation of Benefits)

5. Certification: I certify that I have read the foregoing and understand the nature and purpose of these authorizations to my full satisfaction, and that I am the patient, or am duly authorized by the patient or by court order as patient's legal representative to execute the above and accept its terms.

Client Name (Please Print):	Date:
Signature of Client or Legal Representative:	Relationship to Client / Authority to Give Consent:
Signature of Health Care Provider:	