Aspire COUNSELING

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Consent to Treatment

I acknowledge that I have received, have read (or had read to me), and understand the document "Information for Clients" and/or other information about the therapy I am considering. I have had all my questions answered fully.

I have read and understand the document "Notice of Privacy Practices" and I agree that these practices are acceptable. I understand that this therapist must collect "protected health information" (PHI) about me and that it is necessary for this therapist to decide on what treatment is best for me and to provide treatment to me. I give my consent to this therapist to share this information with others to arrange payment for treatment, to help carry out certain business or government functions, or to help provide other treatment to me.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (e.g. if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist