

CONSENT FOR TREATMENT
&
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Client Name: _____

Date: _____

I sign this form to represent that I have received the Notice of Privacy (HIPAA) Form and I will be given the opportunity to discuss any questions I regarding this policy with Steven E. Wampler, M.S., LCMHC at this and future visits if I need to.

I also recognize that my signature on this form provides consent to Steven E. Wampler, M.S., LCMHC to cover the following situations:

Informed Consent to Treat: Informed Consent refers to a client's decision to allow their health care provider to perform a particular treatment or intervention.

Consent to Release Information: This type of Consent relates to the client's having the knowledge about how to and to whom his/her health information might be disclosed to third parties such as insurance carriers.

Consent to Business Practices: This aspect of Consent relates to the business issues between a client and their mental health provider.

I understand that a use-specific Authorization Form will have to be signed in order for protected health information, including psychotherapy notes, to be released from my clinical records.

Client or Responsible Party Signature

Date