Consent for Treatment

I _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by New Beginnings Counseling, LLC, a behavioral health care provider. 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 patient. If the patient is under the age of nineteen (in Nebraska) or under the age of eighteen (in Iowa) 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.

_____ _____

Signature of Client, Parent/Guardian Date

Relationship to Patient (if applicable): _____

Consent for Use and Disclosure of 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 New Beginnings Counseling, LLC for the purpose of treatment, payment, and healthcare operations. By signing this form, I am agreeing to let New Beginnings Counseling to use my information and send it to others. The Notice of Privacy Practices explains this in more detail. **I have received the Notice of Privacy Practices and understand I should read it before signing this consent.**

✧ I understand that if I do not sign this consent form agreeing to what is in the Notice of Privacy Practices, New Beginnings Counseling cannot treat me and/or my child (ren).

✧ New Beginnings Counseling reserves the right to change its privacy practices. In this case, all current or revised Notices of Privacy Practices may be obtained from New Beginnings Counseling CEO.

✧ 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. New Beginnings Counseling is not required to agree to the restrictions that I may request. However, if New Beginnings Counseling agrees to a restriction that I request, the restriction is binding on New Beginnings Counseling. 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.

_____ _____

Signature of client, Parent, or legal guardian Date

_____ _____

Witness Client's Name

❑ Copy given to Client or Parent/Legal Guardian