The Healthy Foundations Center

Consent to Provide Treatment

(Therapy, Rehabilitative Mental Health Treatment or Life Coaching)

I, ________________________________ (Client/Guardian Name), consent to mental health treatment (Therapy, Rehabilitative Mental Health Treatment or Life Coaching) for myself, or ________________________________ (Child's Name), for whom I am the parent or legally authorized representative.

I am aware that the type and extent of services I will receive will be determined following an assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. I also understand that through the process of therapy and mental health treatment, exploration of possibly uncomfortable emotions and experiences may cause increased emotionality, and can lead to temporary stress or anxiety.

I am also aware that THE HEALTHY FOUNDATIONS CENTER is NOT a 24 hr. crisis intervention provider and that should I be faced with a life-threatening emergency, I should call 9-1-1.

Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality including the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect them and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I am fully aware that if I seek assistance from THE HEALTHY FOUNDATIONS CENTER in accessing community resources and I request transportation from any employee of THE HEALTHY FOUNDATIONS CENTER in efforts to meet my treatment needs, in extreme cases such as auto accident or other physical errors, I release THE HEALTHY FOUNDATIONS CENTER from any and all liabilities and assume all responsibility for my personal well-being and care.

I am aware that if services rendered by THE HEALTHY FOUNDATIONS CENTER are to be billed to my insurance company. I authorize my insurance provider to pay THE HEALTHY FOUNDATIONS CENTER for all services rendered.

I understand that THE HEALTHY FOUNDATIONS CENTER will share patient mental health information according to Federal and State law for treatment, payment and operations.

I have reviewed THE HEALTHY FOUNDATIONS CENTER HIPAA Policy and fully understand my rights.

If I have any questions regarding this consent form or about the services offered by THE HEALTHY FOUNDATIONS CENTER, I may discuss them with my provider. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by THE HEALTHY FOUNDATIONS CENTER. I understand that I may stop treatment at any time.

________________________________ ________________________________

Client/Guardian Name Printed | Client/Guardian Signature and Date

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THE HEALTHY FOUNDATIONS CENTER Representative Name | THE HEALTHY FOUNDATIONS CENTER Representative Signature/Date