38900 harper avenue > clinton township, mi 48036 > 586.463.2921

HIPAA INFORMED CONSENT AND RELEASE FORM FOR COUNSELING SERVICES

______________________________ ______________________________
Name Date of Birth

I acknowledge that I am voluntarily seeking treatment and that treatment will be rendered by a professional counseling therapist.

I understand that the successful termination of treatment is determined when the counselor and client agree that the goals of treatment are substantially achieved. However, I also understand that I am free to discontinue treatment on my own at any time.

I understand that I may ask questions concerning any part of my treatment.

______________________________ ______________________________
Signature Date

Information will be treated confidentially.

(Confidentiality shall not be maintained where there is reason to suspect the occurrence of child abuse or neglect; where there is a clear threat to do serious bodily harm to self and/or others; or where a court intervenes under court order.)

If insurance coverage is requested, I give my permission for information on the diagnosis, treatment, claims payment and mental health care services provided to me to my insurance company in order to pursue utilization of my insurance benefits, and for my insurance to be billed. (A copy of your insurance card and driver's license is required.)

______________________________ ______________________________
Insurance Company Name Policy Number

______________________________ ______________________________
Policy Holder Name Signature

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