



CONSENT FOR EVALUATION/TREATMENT (TO USE AND DISCLOSE HEALTH INFORMATION)

I, _____, voluntarily apply for evaluation/treatment at Arcadia Counseling Center and understand, consent and agree as follows (to be executed by legally authorized person if patient incapable of giving informed consent):

- a.) I have been provided with the intended outcome, nature and procedures involved in the proposed treatment, the risks of not proceeding and alternatives to the proposed treatment; I understand that consent may be withheld or withdrawn at any time with no punitive action taken.
- b.) Information developed as part of the evaluation/treatment and your psychiatric record is confidential but may be released to those parties as required by law, such as (information may be released without my consent) in cases of medical emergency, abuse or neglect, court order, insurance billing claims requirements, and where otherwise legally required. In all other situations a properly executed consent from (which may be withdrawn except to the extent to which it has been acted upon) is required.
- c.) I consent to the use and disclosure of my protected health information (PHI) by Arcadia Counseling Center (ACC) and its staff members, for the purpose of treatment, payment and health care operations. This is a joint consent from between ACC and its staff. I understand the following: My signature on the Consent is required in order for me to receive care from ACC; I have the right to revoke this Consent, in writing, at any time, except to the extent that ACC has taken action in reliance upon this Consent;
I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations of ACC. I realize that ACC is not required to agree to a restriction that I request. If, however, ACC does agree, the restriction must be honored by ACC; I have the right to review the Notice of Privacy Practices (attached) prior to signing this Consent. The Notice may be changed at any time and I can receive a copy of the revised Notice through my provider. ACC agrees to maintain my PHI in accordance with the practices in its Notice of Privacy Practices. This notice also explains my rights with respect to the use and disclosure of my PHI.
- d.) Your evaluation and/or treatment may be staffed between behavioral health professionals within ACC.
- e.) Treatment is individualized to specific needs and may result in emotional discomfort through the healing and recovery process.
- f.) I agree to participate in my treatment planning process to the best of my ability.
- g.) I understand that there is no guarantee that those treatment services prove beneficial to me.
- h.) I understand that if participating in group treatment, all information discussed relating to other clients in sessions is confidential and may not be shared outside of group.

We are required by law to protect your PHI and to abide by the terms of the Notice of Privacy Practices and to provide you with information regarding ACC's privacy policies and practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. We will provide you with any revised Notice of Privacy Practices.

I have reviewed and understand the abovementioned Consent to Treatment and/or Evaluation and to Use and Disclose Health Information, and can request to review the Notice of Privacy Practices, and hereby consent to the evaluation and treatment provided by Arcadia Counseling Center, LLC.

Client Signature

Date

Parent/Legal Guardian Signature

Date

Arcadia Counseling Center, LLC Signature

Date