Pam Raymond, MA, RN, LPC

CONSENT FOR TREATMENT/ ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY

CLIENT: _____

DATE: _____

I sign this form to represent that I have received the *Notice Form* and I will be given the opportunity to discuss any questions I have with this policy with my mental health provider at future visits.

I also recognize that my signature on this form provides consent to Pam Raymond, RN, LPC to cover the following situations:

Informed Consent to Treatment: 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 refers to the client's having knowledge about how and to whom his or her health information might be disclosed to third parties such as insurance carriers.

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

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

_____ _____

Client or Responsible Party Signature Date