Counseling and Health Center, LLP
312 E. College Street Ste. 216 Iowa City, IA 52240
Phone: (319) 337-6998

Client Informed Consent

This document is an agreement between you (responsible adult), _____ and Counseling and Health Center, LLP (CHC). When we use the words "you", "your", and "yourself" below it will mean your child, relative, or other person receiving treatment if you have written his or her name here _____.

By signing this form you are agreeing to let us use your information as described in the Notice of Privacy Practices. The Notice of Privacy Practices explains in more detail your rights and how we may use or share your protected health information, including requirements of disclosure by law. Please read the Notice of Privacy Practices before signing this form. **If you do not sign this form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.**

There is no assurance that you will feel better after engaging in therapy. Some material that may come up in therapy sessions could be upsetting to you, and it may be part of a necessary process for resolving your problems. Additionally, your insurance company may require that your records be reviewed by another provider for the purposes of supervision.

You have the:

- **-right** to be informed of the steps and activities involved in receiving services
- **-right** to confidentiality according to state and federal laws
- **-right** to humane care and protection from harm, abuses, or neglect from the staff
- **-right** to make an informed decision whether to accept or refuse treatment

- **-responsibility** to disclose full information about yourself in order to receive proper care
- **-responsibility** to work with your therapist in developing goals and plans
- **-responsibility** to follow the treatment plan and instructions for care
- **-responsibility** to keep and pay for scheduled appointments or provide 24-hour advance notice of cancellation (see payment policy)

□ **I agree that neither I, nor any person with me, will ever bring any firearms or any other weapons into Counseling and Health Center**

After you have signed this consent, you have the right to revoke it (by writing a letter telling CHC that you no longer consent) and we will comply with your wishes about using or sharing your information from that time on; however, we may already have used or shared some of your information and cannot change what has already been disclosed. If you do not choose to revoke your consent, it will automatically expire one (1) year after the end of treatment or after all claims for treatment have been paid according to provisions of your healthcare program or insurance plan.

_____ _____

Client Signature (If client is under age 18 parent or guardian must sign) Date

Acknowledgement of Receipt of Privacy Practices Notification

Check one option:

____ I have received the Notification of Privacy Practices from Counseling and Health Center, LLP as requested by law.

____I have been offered a copy of the Notification of Privacy Practices from Counseling and Health Center, LLP and have declined them.

_____ _____

Client Signature (If client is under age 18 parent or guardian must sign) Date