Name:_____ **Date:**_____.

SERVICE AGREEMENT

- **Treatment Authorization:**
  The undersigned authorizes _____ to administer mental health and/or chemical dependency treatment to the patient named above. I understand that I may revoke this consent at any time during the treatment period. No guarantee or assurance of results has been made to me regarding the treatment.

  Signature:_____ **Date:**_____.
  Self:_____ Spouse:_____ Parent:_____ Guardian:_____.

- **Information Authorization (Primary Care Physician):**
  I authorize _____ or decline_____ authorization of the release of information to the primary care physician for the purpose of coordinating care.

  Name of PCP:_____ **Phone:**_____.

  Signature:_____ **Date:**_____.

- **Consent for use and disclosure of Personal Health Information (PHI):**
  I have reviewed the Privacy Policy and give consent for the use and disclosure of personal health information to provide treatment, to arrange payment for services, and/or for other health care operations as provided by law. I understand that changes in the policy are possible, and that if there are changes, those changes will be posted in the office for review.
  I understand that I may request in writing that disclosure of my PHI be restricted, and that the therapist is not required to agree to my request. If the therapist agrees to the restriction, that agreement will be honored. I understand that I may revoke this consent, except to the extent that information has already been disclosed.

  Signature:_____ **Date:**_____.

- **Legal Acknowledgments:**
  I understand that my therapist may be required by law to release information without my approval to legal authorities if 1.) there is a clear and serious danger of harm to anyone, 2.) a judge requires specific information in a court case, 3.) it is suspected that criminal offense of a child, disabled adult, or elderly abuse or neglect has occurred.

  Signature:_____ **Date:**_____.

- **Payment Authorization:**
  1.) I understand that I am responsible for payment for any service rendered regardless of whether this service is covered by an insurance policy.
  2.) I authorize insurance benefits payable to those health care providers described above for services rendered by them.
  3.) **I understand and agree to give 24 hours notice if unable to keep any appointment. I understand that if I fail to show for a scheduled appointment, or if I do not cancel with 24 hours notice, I will be charged a <u>$25 noshow fee/Late cancellation fee</u> and will be responsible for payment of that fee.**

  Signature:_____ **Date:**_____.