Client Name: _____ Case #_____

General Consent for Treatment

I, the undersigned,

- Voluntarily consent to treatment with Amy Kinner, LMSW, LLC as recommended and fully explained to me by my therapist and understand that I am free to withdraw my consent and discontinue treatment at any time.
- Understand that treatment with Amy Kinner, LMSW, LLC includes psychosocial evaluation and psychotherapy services. Treatment does not included services by a psychiatrist however I am welcome to seek such services.
- Understand that the confidentiality of records maintained by my therapist is protected by 42 CFR Part 2 and/or CFR Parts 164 & 165 Federal Regulations and MI Complied Laws. My therapist my release client information without client consent under the following specific conditions:
    - Client threatens to harm self or others;
    - Suspicion of child abuse or neglect;
    - Medical personnel, to meet a bona fide medical emergency when there is immediate threat;
    - Authorized by court order under Sub Part E-Section 2.61 of 42 CFR Part 2.

  Federal regulations do not protect any information about a crime committed by a client either at the therapist's office or against any person who works with the therapist or about any threat to commit such a crime.
- Acknowledge that violent or hostile behavior will result in discharge.
- I understand that I will be refused a therapy appointment on any day that I come to my appointment intoxicated.
- Understand that unauthorized photography, audio and/or visual recording are prohibited on the premises.

- Understand that I have rights as a recipient of counseling services and that I have received a description of my rights and that I may receive additional information regarding my rights from Michigan Department of Community Health at www.michigan.gov/mdch. I further understand that I have the right to speak to a Michigan Department Community Health, Office of Recipient Rights Officer, at 800-854-9090, if I feel that my rights have been violated.

Payment for services agreement

- I acknowledge that I have disclosed all information regarding my health insurance and that this information is accurate and complete.
- I accept the responsibility for my fees, co-pays, deductibles, changes in insurance, and for all services rendered to me.
- I authorized Amy Kinner, LMSW, LLC, to submit billing statements to my insurance carrier(s) for the purpose of receiving reimbursement for services until payment is received for all services provided to me.
- I further understand that I am responsible for the cost of my treatment and that I will be billed directly if insurance claims are rejected or denied.

Acknowledgement of Privacy Practices

- I acknowledge that Amy Kinner, LMSW, LLC has provided me Notice of Privacy Practices information about how my protected health information may be used and disclosed. I have been offered an opportunity to review the notice before signing this consent.
- I understand that I have the right to request restrictions on how my protect health information is used or disclosed for treatment, payment or health care operations. My therapist is not required to agree to this restriction but if she agrees, she will be bound by the agreement.
- By signing this form, I acknowledge I have been offered and/or received Notice of Privacy Practices.

By signing this form I acknowledge that I have had the opportunity to read this form (or have it read to me), ask questions and have these questions answered. I understand and agree to the statements on pages 1 & 2 of this form.

Client Signature Date