COUNSELING AND COPING STRATEGIES, LLC

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I give my consent to be diagnosed and treated by Counseling and Coping Strategies (CCS), LLC. for the purpose of diagnosing or providing treatment to me, obtaining payment for these mental healthcare services and counseling. I understand that the diagnosis and treatment of me by CCS may be conditioned, upon my consent, as evidence by my signature on this document.

I have the right to revoke this consent, in writing, at anytime, except to the extent that the counselor may have already taken some actions in reliance on the consent. Furthermore, CCS, reserves the right to change the policy practices that are described in the Notice of Privacy Practices, and I will be notified of those changes in writing.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my counselor, another healthcare provider and my employer or a healthcare-clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable belief that the information may identify me.

I understand that I have the right to review the Notice of Privacy Practices provided by CCS before signing this document. The notice of Privacy Practices describes the types of uses or disclosures of my protected health information that are allowed in my treatment, payment of my bills and in the process of healthcare operations. The notice of Privacy Practices also describes my rights and the duties of CCS to protect my health information.

I understand that I have the right to request a restriction as to how my protected health information may be used or disclosed to carry out treatment, payment or healthcare operations of this practice. CCS is not required to agree to the restrictions that you may request. However, if CCS agrees to a restriction that you request, the restriction will be binding on the day of request in writing.

_____ Date_____

(Print Name of Patient or Personal Representative)

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(Signature of Patient or Personal Representative

Description of Personal Representative Authority:_____