Freedom Counseling Center, inc.
(269) 982-7200 FAX (269) 982-0202

INFORMED CONSENT FOR TREATMENT

I _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by _____ (name of provider), a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above provider is qualified to provide within: (1) the scope of the provider's license, certification, & training; or (2) the scope of license, certification and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual & consent to treatment on behalf of this individual.

Signature _____ Date_____

Relationship to Patient (if applicable): _____

TELEPHONE NOTIFICATION CONSENT

Patient confidentiality is a top priority at Freedom Counseling Center, Inc. In order to meet your needs in regards to this matter, we are asking that you sign a release allowing us to provide automatic appointment reminders by text message, email or automated phone call.

Select One Option Below

☐ Freedom Counseling Center may send cell phone text messages to
Confirm my upcoming appointments at: _____

☐ Freedom Counseling Center may send email messages to confirm
my upcoming appointments at: _____

☐ Freedom Counseling Center may make automated phone messages to confirm my upcoming appointments at: _____
_____

☐ I do not have an email address, or ability to get text message reminders,
please call me personally for reminders at: _____
Messages may be left with: _____

☐ I do not want text message, email or automated phone reminders.

_____
Patient Name (please print)

_____ _____
Patient's/Parent or Guardian Signature Date

HIPAA NOTIFICATION

Your signature below indicates that you have read Psychotherapist-Patient Service Agreement & the Michigan Notice Form (Notice of Psychologist's Policy & Practices to Protect the Privacy of your Patient Health Information), agree to abide by its terms during our professional relationship, & have received the HIPAA's Notice Form.

Your signature also verifies the telephone notification consent.

_____
Patient Name (please print)

_____ _____
Patient's/Parent or Guardian Signature Date

PRINT RESET