L.I.F.E.
Lifting Individual & Family Expectations, Inc.
...supporting individuals and empowering families

Consent to Treatment

I, _____ **(client name),** understand that all information, including assessments, treatment notes, treatment/service plans etc. are treated with the strict confidentiality and that no information, either verbal or written, will be shared without the written consent of client/legal client guardian (if client is under the age of 18) _____**, (parent/legal guardian name).**

I understand that individuals responsible for my care through Lifting Individual and Family Expectations (LIFE), Inc. need to have access to confidential information for the purpose of assessment, coordination of care and to ensure quality of care provided to me.

By law, rules of confidentially do not hold under the following conditions:

- If abuse or neglect of a minor, disable or elderly person is reported or suspected, the provider is legally required to report the concern to the Department Of Children and Families.
- If, during services, a LIFE, Inc. provider receives information that someone's life is in danger, that provider has a legal duty to warn the threatened individual.
- If LIFE, Inc. contracted providers or employee's testimony is subpoenaed by a Court Order, we are required to produce records or appear in court to answer questions about the client.

I consent to the following services: ☐ Mental Health Therapy ☐ Acupuncture ☐ Nutrition Therapy ☐ Massage Therapy ☐ Other Service_____

I consent to treatment taking place at the following location(s): ☐ Office ☐ Video Conferencing

I authorize the release of any medical or any other information to Lifting Individual and Family Expectations, Inc. or its billing company designee that is necessary to process this claim.

I also authorize Lifting Individual and Family Expectations, Inc. or their billing designee to submit claims for services rendered to my insurance company or other payment source and receive full payment for services rendered.

I agree that full payment, co-payment, percentages and/or deductibles are due at the time services are rendered.

Information on this page has been explained to me. I understand that I may revoke this consent at any time by notifying the facility in writing, except to the extent that action has been taken in reliance on my consent.

Revoking consent will not exclude Lifting Individual and Family Expectations, Inc. or its billing company designee from submitting claims and receiving payment for services rendered prior to terminating the consent. A photocopy of this authorization is to be considered as valid as the original document. The duration of this authorization is 12 months from the date of signature.

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature (if client under 18) Date

_____ _____ _____ _____
Behavioral Health Provider Name Behavioral Health Provider Signature Credentials Date