Omaha Psychotherapy

6910 Pacific Street, suite 320
Omaha, NE 68106

(402) 715-9710
omahapsychotherapy.com

After reviewing the policies and service agreement, privacy policy and HIPAA form, please sign the following consent for treatment. If you are under the age of 19, your parent or legal guardian must sign these consents.

**I. INFORMED CONSENT FOR TREATMENT**

I, ___________________________ acknowledge I have been given the opportunity to review my rights and responsibilities in the therapeutic relationship as described in the document "Policies and Service Agreement" and have been given an opportunity to ask any questions I may have about this process.

- I consent to participate in, or allow my child to participate in, evaluation and psychotherapy treatment provided by Omaha Psychotherapy.

- I understand the practice of psychotherapy is not an exact science and that results cannot be guaranteed. I am aware I may stop treatment with my provider at Omaha Psychotherapy at any time.

- I understand I am financially responsible for all evaluation and treatment charges not covered by insurance. Charges may include insurance deductibles, co-insurance or out-of-pocket expenses such as late cancellation or no-show fees. My signature below indicates I have read, understand and agree with the above statements.

______________________________________________________________________________

(Signature of Client or Personal Representative) (Date)

**II. CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

As stated in the Privacy Policy, Omaha Psychotherapy is allowed to use or disclose your protected health information (PHI) in order to provide treatment, obtain payment for services, and for other professional activities known as "health care operations" (such as billing services). Your signature below gives permission to use or disclose your PHI for these purposes.

- You may ask to restrict the use and disclosure of certain PHI that would otherwise be allowed for the purposes noted above. However, we do not have to agree to these restrictions.

- You may revoke this consent at any time by giving written notification, and Omaha Psychotherapy will comply with your restriction request from that time forward. However, your provider may have already used or disclosed some of your information, and cannot change that after the fact.

- This consent is voluntary; you may refuse to sign it. However, Omaha Psychotherapy is permitted to refuse to provide services to you if consent is not granted, or if consent is later

revoked. I hereby consent to the use or disclosure of my protected health information as specified above.

______________________________________________________________________________
(Signature of Client or Personal Representative) (Date)

**III. ACKNOWLEDGMENT OF RECEIPT OF PRIVACY POLICY**

I hereby acknowledge I have received, and have been given an opportunity to read, a copy of the Omaha Psychotherapy Privacy Policy. I understand that if I have any questions regarding the Polciy or my privacy rights, I can contact Omaha Psychotherapy, 6910 Pacific Street, suite 320, Omaha NE, 68106 or by phone at 402-710-9710.

______________________________________________________________________________
(Signature of Client or Personal Representative) (Date)

______________________________________________________________________________
(Responsible Party's Relationship to Client (parent, power of attorney, etc)

______________________________________________________________________________
(Signature of Witness from Staff) (Date)