**Top of Form**

**Acknowledgement of Receipt of Notice of Privacy Practices and Client Rights**

I, , acknowledge that I have received a copy of the Notice of Privacy Practices that summarizes the ways my identifiable health information may be used and disclosed by this provider, and also states my rights and respect to my medical information. I understand that this provider has the right to revise and to amend the Notice of Privacy Practices. I have been informed that, in the event this provider revises the Notice of Privacy Practices, a revised Notice of Privacy Practices will be posted by my service provider. I may obtain a current notice at any time from my service provider. I also acknowledge that I have received a copy of the Client Rights and Responsibilities/ Explanation of Services that details the ways I will be treated, my responsibilities, and an explanation of the services I will receive.

Client Signature Date

Guardian Signature Date

Witness Signature Date

**Consent for Treatment**

I, , hereby give my consent for evaluation and treatment to administered by this service provider. For persons under the age of 18, I give this consent with or without my presence. I understand that if I do not revoke my Consent for Treatment, it will expire automatically one year from the date of signature.

Client Signature Date

Guardian Signature Date

Witness Signature Date

***Hope & Healing Counseling, LLC***

*1200 Valley West Drive, Suite 304-04*

*West Des Moines, IA 50266*

*(515) 421-4367*