Braun Counseling Services LLC

Diane Braun LIMHP, LMHP, LADC, CPC

Client Consent for Treatment/Services

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Client Name Date of Birth Client Number

\_\_\_\_\_\_\_ (Initial) **Authorization for Treatment:** I hereby authorize Braun Counseling Services LLC and/or its representatives to provide care, support, and or behavioral health services and/or treatment as may be necessary of advisable in treating me, or the individual for whom I am legally authorized to provide this consent’s symptoms, diagnosis, mental health concerns and/or supportive needs. I am aware the practices authorized hereunder are not an exact science and I acknowledge no guarantees of any particular outcome or result have been made to me related to the services or treatment I am authorizing Braun Counseling Services LLC and/or its representatives to provide. I also understand that my therapist may provide me with referrals for additional services.

\_\_\_\_\_\_\_\_ (Initial) **Acknowledgment of Clients Rights and Responsibilities:** I acknowledge that I was offered my therapist’s Rights and Responsibilities. My rights and responsibilities have been adequately explained to me and my consent given is with full knowledge of the consent of these rights and responsibilities.

\_\_\_\_\_\_\_\_ (Initial) **Acknowledgement of Agencies Privacy Practices:** I have been given the opportunity to read the agency’s Notice of Privacy Practices and seek clarification on any part I do not understand. I have been offered a copy of their Privacy Practices.

\_\_\_\_\_\_\_\_ (Initial) **Emergency Medical Treatment:** I understand that my therapist and/or agency staff will call 911 for me or the individual’s treatment in the case of an apparent medical emergency, whether physical or emotional, while in the agency’s office or during face to face services provided to me or the individual treated.

\_\_\_\_\_\_\_\_ (Initial) **Authorized Representative:** I hereby authorize Braun Counseling Services LLC and/or representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided by him.

I hereby acknowledge that, when appropriate, my therapist may collaborate regarding my case for the purposes of referral, treatment and/or coordination of care.

**The undersigned certifies that he or she has read and understands the above mentioned and is the client, client’s guardian, power of attorney, parent, or duly authorized by or on behalf of the client to execute the above and accept its terms.**

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Signature of client or guardian Relationship to client Date

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Signature of therapist Date

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Signature of Interpreter Date