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ROSEMARY PRIEST, LPC, LMFT, LMHC, NCC
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Tulsa, Oklahoma 74136
918-747-1649
Fax: 918-528-4344

TREATMENT AUTHORIZATION

I acknowledge that the information I share about myself and my concerns is considered confidential and will not be shared with anyone without my written consent EXCEPT under the following circumstances:

1. In extreme circumstances such as a life-threatening emergency.
2. To discuss your benefits or case with your managed care and/or insurance company.
3. A specific court order signed by a judge.
4. The State of Oklahoma law requires that any information regarding abuse of a child, disabled adult, or aged person be reported to the State Abuse Registry who will investigate the situation.
5. Any criminal behavior has been revealed.

I am aware that while receiving treatment or services I have the right to quality treatment, individual privacy, dignity and compassion. I am aware that I will not be discriminated against on the basis of race, color, religion, sex, national origin, age, sexual preferences or physical ability. I am aware that I have the right to refuse treatment except in an emergency situation. If I do refuse treatment in an emergency situation, I have the right to be informed about the responsibility of the therapist to seek appropriate legal alternatives. Otherwise, I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have received.

I am aware that if I become dissatisfied with the services I receive, I can attempt to resolve these differences with my therapist. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I have been informed of and understand the above guidelines for treatment services and I hereby authorize ROSEMARY S. PRIEST, M.S., LPC, LMFT, LMHC, NCC to provide mental health counseling or other services as deemed appropriate and/or necessary.

____ __________ I have been provided a Notice of
Signature (Adult) Initial Privacy Practices Form

____
Printed Name

____ ____________________________________
Date Signature of Therapist Date

AUTHORIZATION FOR THE TREATMENT OF MINORS: I hereby authorize Rosemary S. Priest, M.S., LPC, LMFT, LMHC to administer services and/or treatment to my child who is under the age of 18.

____________________________ Date:__________ ________________________ Date:_______
Signature of Parent or Guardian Signature of Minor