Salus
COUNSELING, LLC

CONSENT FOR TREATMENT AND ACKNOWLEDGMENT OF OFFICE POLICIES

SalusCounseling.com
SalusCounseling@ymail.com

I, hereby acknowledge that I have received, read and been given an opportunity to ask questions regarding the following Salus Counseling business documents: Counselor's Informed Consent and Procedures, including the following:

- Salus Counseling's Informed Consent and Procedures
- Client Bill of Rights
- Agreement to Pay
- Insurance Assignment of Benefits
- Emergency Procedures
- HIPAA-Notice of Privacy
- Authorization for Live Observation: I, voluntarily consent to live observation by a Treasure Wellness Counseling Center Intern for the educational training of Interns. Yes No (circle one) _____ (Client's Initials)

I, voluntarily consent to participate in the intake, assessment and treatment process. I also acknowledge the following to be true:

1. I have been given the opportunity for discussion of any concerns that I have regarding treatment.
2. I will be informed and take part in my treatment and goal planning.
3. I have been given no guarantee of treatment outcomes.
4. I have been informed of any and all fees associated with my treatment.
5. Treasure Wellness Counseling Center will use and disclose personal health information for treatment and to receive payment for services provided.
6. I understand that if I have any questions or concerns regarding these business documents, I may contact my clinician or the Treasure Wellness office.

_____ _____ _____

Printed name of Client | Signature of client (or guardian for client) | Date

I, the counselor, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Karin Watson, LCPC | Date