IHEARU MENTAL HEALTH
Consent for Treatment and Billing Authorization

Patient Name: ____
Facility/Treatment Location: ____

I hereby consent to the services of IHEARU Mental Health and to their healthcare providers, which include a psychological evaluation and continued supportive therapeutic services.

Mental Health Therapy & Counseling Information Disclosure Statement

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. As a client in mental health therapy, you have certain rights that are important for you to know about. There are also certain limitations to those rights that you should be aware of. As a therapist, there are corresponding responsibilities to you as well.

I. Confidentiality - Except for certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. Your provider will always act to protect your privacy and share information with only the people you designate. You may direct your provider to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you.

II. Record-keeping – Brief records are kept, noting only that you have been in session, what interventions happened in session, and the topics that were discussed. You have the right to request that any errors in your file be corrected. Your records are maintained in a secure location that cannot be accessed by anyone else.

III. Other Rights - You have the right to ask questions about anything that happens in therapy. Your provider is willing to discuss how and why they have decided to do what they are doing and look at alternatives that may work better to ensure your potential therapeutic needs are met.

IV. Billing and Authorization - I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, information to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I certify that the information given me in applying for payment under Title XVIII of the Social Security Act is correct.
For these services I authorize payment directly to the above-named Medicare provider by Medicare, health insurance and or third-party benefits. I understand the provider of services accepts **assignment.** I hereby authorize payment directly to IHEARU Mental Health or to their designated healthcare provider.

I give consent for mental health counseling. I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and the release of information necessary to complete the billing process. I understand I may withdraw my consent at any time.

Signed:____________________________ **Print Name:** ________________________**Date:**___________________

If patient unable to sign (relationship) ______________________________________**Date**___________________