



**CONSENT FOR EVALUATION/TREATMENT  
AND TO USE AND DISCLOSE HEALTH INFORMATION**

I understand that the treatment services provided by McDowell Mountain Counseling are offered with respect for the dignity and rights of the individuals and families seen. I hereby authorize McDowell Mountain Counseling to conduct an evaluation and perform treatment for myself and/or my couple/family/child with regard to behavioral health problems. My signature below indicates that I have read and agree with the following:

- (a) I have been provided with the intended purpose, outcome(s), nature and procedures involved in the proposed treatment, the risks including side effects (if any) as well as the risks of not proceeding and alternatives to the proposed treatment (particularly those offering less risk or other adverse effects). I understand that consent may be withheld or withdrawn at any time with no punitive action taken.
- (b) Information developed as part of evaluation/treatment and your treatment record is confidential but may be released to those parties as required by law, such as in cases of medical emergency, abuse or neglect, court order, insurance billing claims requirements, and where otherwise legally required. In all other situations, a properly executed authorization form is required, which may be withdrawn at any time except to the extent to which it has been acted upon.
- (c) I consent to the use and disclosure of my protected health information (PHI) by McDowell Mountain Counseling for the purpose of treatment, payment and health care operations.
- (d) I understand that my signature is required in order for me to receive care from McDowell Mountain Counseling. I have the right to revoke this Consent, in writing, at any time, except to the extent that action has been taken in reliance upon this Consent. I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations. I understand that McDowell Mountain Counseling is not required to agree to a restriction that I request, but all agreements made by McDowell Mountain Counseling will be honored. I have the right to review the Notice of Privacy Practices prior to signing this Consent. This Notice of Privacy Practices may be changed at any time and I can receive a copy of the revised this Notice through my Clinician. McDowell Mountain Counseling agrees to maintain my PHI in accordance with the practices in its Notice of Privacy Practices.
- (e) Your evaluation/treatment may be staffed by our professionals in supervision.
- (f) I agree to participate in my treatment planning process to the best of my ability.
- (g) I understand my right to be informed of all fees I am required to pay and all refund and collections policies of McDowell Mountain Counseling.
- (h) I understand that there is no guarantee that the treatment services provided by McDowell Mountain Counseling will prove beneficial to me.

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Signature of Client/Legal Guardian of Minor

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Date

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Signature of Treating Clinician

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Date

