Northwest Counseling and Psychotherapy Center

30375 Northwestern Hwy, Suite 200
Farmington Hills, MI 48334
248-254-3332 (Phone)
248-254-3333 (Fax)

Consent to Treatment

I voluntarily hereby give my consent to NCPC to provide evaluation, treatment and/or other services that we may mutually determine to be appropriate. I have the right to refuse any treatment or medication. If so, the outcome of refusal will be explained to me. I understand that NCPC staff may review my records as part of my care. All clinical care will be rendered by a qualified and trained professional. A description of services, methods, and benefits of these services has been provided. I further understand that these services are confidential and that information about myself or my child will not be disclosed or released to anyone other than authorized NCPC staff without my written consent, with the following exceptions:

- Information needed for my insurance company to process claims as well as other external auditing bodies to insure quality of care.
- If I disclose information in the course of evaluation or treatment which indicates I present a clear and present danger to myself or a specific other.
- If there is reason to suspect that a child is being abused or neglected.
- If my records are subpoenaed by a court of law.

As a client of NCPC, I agree to: (1) Respect the confidentiality of other clients attending NCPC, (2) Maintain scheduled appointments; or if necessary, to cancel with 24 hours notice, (3) Cooperate with the development of my treatment plan. My treatment goals are:

A) _____, B) _____, C) _____

Patient's Rights and Responsibilities

I have received my copy of the Patient Rights brochure (including grievance process) and a copy of NCPC Notice of Privacy Practices explaining my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and they were explained to my satisfaction. ☐ I Agree

Authorization to Release Information

I authorize any holder of medical information about the person receiving treatment, named below, hereafter referred to as patient to release any information requested relating to this or any related episode(s) of care. I authorize NCPC to release any information acquired in the course of the evaluation or treatment of the patient to any related government or insurance carriers from whom application has been made for benefit payment; to any physician, hospital or other care facility which has provided treatment to the patient, and/or accrediting agencies during a review process. ☐ I Agree

Authorization for Payment

I authorize that No-shows or cancellations without 24 hour prior notice will be billed $ _____ to my account. (Insurance will not pay for No-shows or cancellations.) I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to NCPC. I understand that the fee for service will be $_____ and that although my insurance may be billed, I am ultimately responsible for payment. I further agree that any co-pays must be paid at the time that the service is rendered unless other arrangements have been made. I will be notified of any changes in my health care coverage if NCPC becomes aware of said changes after verification of benefits. ☐ I Agree

Print Patient's Name	Patient's Representative and Relationship
Signature of Patient or Representative	Date
Therapist's Signature	Date