CONSENT TO TREATMENT AND CLINICAL SERVICES AND HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Client's Name:_______________________________ **Date of Birth: _________________**

I give my permission to Neurobloom Psychological Clinic (NPC) to provide mental health, counseling, psychiatric and educational services, and any testing/treatment related to those services to me or my dependent.

I understand that the services received at NPC are based on currently accepted practice in the fields of mental health or substance abuse. I also understand that the outcome of treatment cannot be guaranteed and that the services continue with my voluntary consent.

If my dependent or I threaten to harm either myself or someone else, I understand that the law obligates NPC to take whatever action is necessary to protect people from harm. This may include divulging confidential information to others. Such action would be taken when someone's life appears to be in danger.

I understand that if my dependent or I have been ordered by the court to seek treatment or diagnostic services, the court will require one or more reports. My written consent to release information will be requested.

I understand if my dependent or I have been involved in litigation of any kind and the court is informed of mental health/substance abuse treatment, I may be waiving the right to keep records confidential. I further understand I may want to consult with my attorney before disclosing to a court that my dependent or I are receiving treatment or diagnostic services.

I understand it may be necessary to reach me by mail, email or telephone during or after my or my dependent's treatment for the purpose of scheduling or confirming appointments, billing or payment issues, completion of forms, conducting surveys or any necessary follow-up. I also understand that to communicate via email or text message, I will provide consent, recognizing that email or text message is not a secure form of communication. There is some risk that any protected health information that may be contained in such email or text message may be disclosed to or intercepted by unauthorized third parties.

I understand that the State of Michigan and Federal laws and regulations do not protect any information about suspected child and/or elder abuse or neglect from being reported to the appropriate state or local authorities.

I am voluntarily authorizing diagnostic and/or treatment services for my dependent or myself. I may refuse any aspect of treatment, understanding that such a refusal could, in some instances, result in termination of treatment and/or services.

I acknowledge that NPC's notice of privacy practices is available upon request at any time.

___ I authorize NPC to communicate with me via text message

___ I authorize NPC to communicate with me via email at this address _________________

By signing below, I agree to comply with the policies and procedures of NPC

____ __________________________________

(Client/Parent/Guardian Signature) Date (Witness) Date