WHOLENESS TO FREEDOM MINISTRIES INC.

Susan E. Begley LMHC, CETP; License #MH 11717

CONSENT FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

SECTION A: CLIENT GIVING CONSENT (**Couples**)

NAME: _____ DOB: _____ SS# _____

NAME: _____ DOB: _____ SS# _____

ADDRESS: _____
CITY/STATE ZIP CODE

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out diagnosis and treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions to our notice, at any time by contacting our office at the above address and/or telephone number.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you refuse to sign , or revoke this Consent.

Printed Name (Couples please print both names)

We, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. We understand that, by signing this Consent form, we are giving our consent to your use and disclosure of our protected health information to carry out diagnosis and treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,

but was unable to do so as documented below:

Date	Initials	Reason

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SECTION C: CONFIDENTIALITY POLICY

Limitation on Confidentiality when Providing Therapy to Couples or Families

This written policy is intended to inform you, the participants in therapy, that when working directly with couples and/or families, that the couple or family is considered to be the treatment unit or the client. During the course of our work together smaller parts of the treatment unit (e.g. an individual, two siblings, the couple) many attend sessions apart from the whole unit. Although separate, these sessions are to be seen as a part of the work that is being done with the whole treatment unit unless otherwise indicated. Generally these sessions are confidential and follow the above guidelines (1-4) as stated above meaning that no confidential information to a third party will be released unless required by law to do so and/or without your written authorization, as well as each member of the treatment unit. However certain limitations apply to this policy when considering working with the smaller parts of the treatment unit to most effectively serve the treatment unit as a whole. There is a "no secrets" policy due to the fact that secrets tend to divide rather than unit families and interferers with treatment goals; therefore you are agreeing to the free exercise of the therapist clinical judgment regarding the need to disclose information to the treatment unit with the following guidelines.

- All information within sessions, apart from the treatment unit, remain confidential unless the information learned in the course of an individual session is relevant or even essential to the proper treatment of the treatment unit.
- The therapist will use his/her best judgment as to whether, when, and to what extent disclosures will be made to the treatment unit.
- The therapist will encourage and provide the opportunity for the individual or the smaller part of the whole to make such disclosures with the proper support to do so.
- Individuals within the treatment unit that find it necessary to talk about matters they absolutely want to remain confidential and shared with no one agree to consult with an individual therapist separate from the treatment unit therapist.

We, the undersigned members of the _____ (couple unit), acknowledge we have read, discussed together and fully understand this stated policy and agree to honor this policy.

Signature _____ Date _____

Signature _____ Date _____

Counselor _____ Date _____