WHOLENESS TO FREEDOM MINISTRIES, INC.

James L. Begley Jr. M-Div, BCPC

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

SECTION A: CLIENT GIVING CONSENT (INDIVIDUAL)

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 is available on display in our lobby or you may request a personal copy. 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.

SIGNATURE

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

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

We, the undersigned therapist and client, have read, discussed together and fully understand this stated policy and agree to honor this policy.

Client signature _____ Date _____

Counselor signature _____ Date _____