Healing Hope Counseling Center, LLC

Consent to Treat

_____ I agree that Healing Hope Counseling Services, LLC will provide services to myself/ or child. I have freely chosen to come to Healing Hope and realize I/ we could've chosen another place to receive this same service.

Release of Medical INFO and authorization to pay insurance benfits.

_____ I authorize my provider to release information from my medical record to my insurance carrier for the process of claims for medical benefits. I request that my insurance provider pay my provider on my behalf after they honor my insurance benefit applicable to the counseling services I receive.

I understand the purpose for and have completed the following:

_____ Financial Agreement

_____Release of information

_____Consent to Treat

_____Client Rights

_____ I was offered HIPPA Privacy Rights.

Signiture:_____Date:_____