The Whole Child Associates, LLC

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THE WHOLE CHILD ASSOCIATES POLICIES AND CONSENT FORMS

PATIENT NAME: _____

CONSENT TO EVALUATE AND TREAT

I, for myself, or the patient named above, hereby consent to such medical evaluation and/or treatment and diagnostic procedures (e.g. x-rays, MRI, videotaping) as necessary and appropriate for my condition or illness based on the judgement of my health care provider(s). I have had, and will continue to have, an opportunity to discuss treatment options with my health care provider, ask questions regarding such treatment options and understand the options discussed.

NOTICE OF PRIVACY PRACTICES AND CONTACT AUTHORIZATION

The **NOTICE OF PRIVACY PRACTICE (NPP)** tells you how we may use and share your health records. It also describes your rights with respect to your health records. **Please read it. The NPP is available at The Whole Child Associates.**

- We will use and share your health records to treat you and to bill you for the services provided.
- We will use and share your health records to run our business.
- We will use and share your health records as required/allowed by law.

CONTACT AUTHORIZATION (Please CHECK the appropriate answer below)

Do the therapists and staff of The Whole Child Associates have your permission to leave messages containing medical and/or financial information on your voicemail or answering machine?

At Home_____YES _____NO

At Work_____YES _____NO

On Cell _____YES _____NO

**If you check "NO", the date, time, and location of appointments will be left on your voicemail/answering machine.*

The individual(s) named below will also be your emergency contact(s) unless you specify otherwise.

Please complete below: **I give authorization to the staff of The Whole Child Associates to discuss my medical and/or financial information with the following people:**

NAME	RELATIONSHIP	PHONE