



Consent to use and disclose your health information

This form is an agreement between you, _____ and Jeffrey A. Betman, Ph.D. When I use the word “you” below, it will mean your child, relative, or other person if you have written his or her name here

_____.

When I examine, diagnose, treat, or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in my Notice of Privacy Practices I cannot treat you.

In the future I may change how I use and share your information and so may change the Notice of Privacy Practices. If I do change it, you can get a copy from me by calling 248-324-9094.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if we do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

I have read the *Notice of Privacy Practices* and the *Psychotherapy Services Agreement*. I understand and agree to comply with all of the policies and procedures described in these documents.

Client Name (Print)

Date

Signature

Therapist Name

Date

Signature

Date NPP _____ Copy given to client/parent

CANCELLATION POLICY

There is a 24-hour notice required for all cancellations. If I do not receive 24-hour notice you will be charged \$75. I have voicemail so that you may leave a message. I have read and understand the cancellation policy stated above.

Signature

Date