Hendricks Therapy
Consent for Treatment and Acknowledgments

Current Date: Patient: Date of Birth:

Consent for Health Care Services: I authorize consent for my treatment at Hendricks Therapy. **By signing below, I represent the following to be true:**

I acknowledge and confirm that:

- I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.
- I am responsible for the payment and/or co-payment that is due at the time of service.
- I authorize Hendricks Therapy and any of it's affiliates, agents, contractors, or creditors to contact me by the phone numbers and emails provided to Hendricks Therapy both now and in the future. **This includes communications by automated dialers and messaging equipment.**
- I have been offered the current Notice of Privacy Practices to review, and I understand and agree to the terms established therein. I further understand that I can request a copy of Hendricks Therapy's current Notice of Privacy Practices at any time by asking a member of staff.
- I have received a copy of Hendricks Therapy's Patient Information, which contains the Patient Agreement with Hendricks Therapy. I understand and agree to comply with all expectations established therein, including all financial responsibility should insurance not pay or for No show/ Late cancellations fee of $65. ☐ **INITIAL**

Consent to Release Information to additional Individuals:

- I authorize Hendricks Therapy to inform the individual(s) listed below, if any, about my general medical condition, diagnosis, appointment scheduling, and account (including treatment, payment, and healthcare operations) as specified by checking the boxes below.
- I understand that I may revoke this privilege at any time by notifying Hendricks Therapy in writing.

Name AND Relationship to Patient	Phone	Schedule/ Cancel Appointments ONLY	All Medical and Account Information	Emergency Contact?
		☐	☐	☐
		☐	☐	☐

Patient / Legal Representative Signature **If other than Patient, Name and Relationship to Patient**

Primary Care Physician / Therapist Information and Authorization

I authorize Hendricks Therapy to release any/ all of the information selected to the Primary Care Physician or Therapist listed below:

☐ Treatment plan / Diagnosis/ Meds ☐ Acknowledgment Shared Patient Letter ☐ Please do not send any Information

Name of Primary Care Physician

Address City State Zip

( ) ( )

Phone Fax

Were you referred to our offices by the PCP or Therapist listed above? **YES** ☐ **NO** ☐

If not, who referred you to our offices?

- I understand this authorization is valid for disclosure of Alcohol and Drug Abuse and HIV/AIDS, Communicable Disease Information. Information that has been released is no longer protected by Hendricks Therapy and may be subject to re-disclosure by the recipient, even though further disclosure of this information is prohibited unless permitted by the written authorization of the client, or their legal representative. This is in accordance with 42 C.R.R.21. A copy of this authorization shall be as valid as the original.
- I understand I have the right to revoke this authorization by sending a written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
- I understand that Hendricks Therapy will not withhold treatment from me if I refuse to sign this Authorization for Use/Disclosure of Medical Information form.
- **I understand that this authorization is Limited to the Purpose and to the Person/Parties listed above and will be in effect for the duration of my treatment** unless I revoke this authorization in writing.

Patient / Legal Representative Signature **If other than Patient, Name and Relationship to Patient**