TRAILHEAD COUNSELING
MINDFULNESS • INTEGRATION • REGRESSION

CONSENT FOR MENTAL HEALTH TREATMENT

_____ CONSENT TO TREAT:
I understand Trailhead counseling provides mental health counseling and treatment services. I agree to treatment for:

□ myself □ my child □ person I have legal guardianship over

_____ CLIENT RIGHTS AND RESPONSIBILITIES:
I have received the Client Rights handout and relevant handouts outlining my responsibilities as a client of Trailhead Counseling. I understand that is my right to ask questions if I have concerns or if I need clarification.

_____ ACKNOWLEDGMENT OF PRIVACY NOTICE:
I have received a copy of the current Notice of Privacy Practices.

_____ FINANCIAL AGREEMENT AND/OR ASSIGNMENT OF BENEFITS:
I request my insurance company or third party coverage to pay all claims directly to Trailhead Counseling. If my insurance determines a service is not covered, I understand that I am financially responsible for full payment of therapy charges. I understand I am financially responsible for any co-payments determined by my insurance benefits, and this payment is expected at time of service. In the event that I fail to honor my financial obligation to Trailhead Counseling, I understand my services may be re-scheduled and/or terminated.

_____ COORDINATION OF CARE:
I understand it may be necessary for Trailhead Counseling to communicate protected health information to other providers in coordination of care. Ex: prescriptions, insurance billing, crisis.

_____ _____
Client signature Date