Consent Form

Client Name: ____ **DOB:** ________________________
Spouse/Parent Name: ____ **DOB:** ________________________
Family Member's Name: ____ **DOB:** ________________________
Address: ____
Home Phone: ____ **Cell Phone:** _______________________________________

Records Release: I hereby authorize the release of any information, including medical and billing information, by Lighthouse Child & Family Services to my referring doctor, insurance company, contracted billing company with LCFS, the responsible party named above, and immediate family on behalf of myself and/or dependents. *Initial here* __________

Assignment of Benefits: I hereby authorize payment of Medical Benefits to Lighthouse Child & Family Services for services rendered to myself and/or dependents. *Initial here* __________

I understand that I will accept financial responsibility if the following occurs:

- If I fail to obtain a referral from my insurance carrier or medical doctor as directed by my insurance policy.
- I choose to continue to receive services my insurance has already denied, or as stated in my policy, as a service that will not be covered.
- I choose to continue to receive services beyond what my particular insurance policy will cover for that specific service.
- I have received services at a time when my insurance coverage has lapsed or has been terminated. *Initial here* __________

Acknowledgement of Receipt of Notice of Privacy Practices: I have read, or had read to me, and offered a copy of Notice of Privacy Practices and have received a copy of Notice of Privacy Practices/Tennessen/MN Data Practices Act/HIPPA. *Initial here* __________

Minor Children Only: I give consent for my minor child to receive therapeutic services in my presence or in my absence.
Initial here __________

Physician Release *(please indicate which option)*:
___ No physician at this time.
___ I do NOT authorize the release of information to/with a physician at this time.
___ I authorize the release and exchange of clinical and/or medical information with my physician.
Initial here __________

Consent for Consultation: The therapists at Lighthouse Child & Family Services, LLC meet regularly for clinical consultation. I am aware of this and give my consent for confidential clinical review of my case. *Initial here* ___________________

Consent to Share Data with DHS: If you are receiving services through a DHS certified or funded program, you authorize LCFS to share necessary data with DHS for reporting purposes. Initial here ________________

Appointment Reminder by Text: I request to be notified of upcoming appointments through text messaging, and I agree to pay the standard text messaging rates for this reminder service, if applicable. Use number listed above. *Initial here* ___________________

Health Care and Advance Psychiatric Directives (18 years and older): Do you have a Health Care Directive or an Advance Psychiatric Directive?
Yes____ No____ If no, are you interested in receiving information regarding either? Yes____ No____

Consent for Treatment: By signing below, you agree to all initialed items listed above and consent for treatment by Lighthouse Child & Family Services, LLC.

X____ X________________________
Signature of Client/Responsible Party Date

For reporting purposes only:

Race: ☐White ☐Black/African Amer. ☐Amer. Indian ☐Alaskan Native ☐Asian ☐Other ____________
Ethnicity: ☐Latino/Hispanic ☐Somali ☐Hmong/Loation ☐African ☐Other
Spoken Language ____________________________________ Do you have a need for an interpreter? Yes/No