Consent for Treatment

Client (print) _____ File number: _____

I, _____, hereby attest that I am voluntarily entering into treatment, or give my consent for the minor or person under my legal guardianship named above to have treatment at New Hope Counseling Services, P.A. The rights, risks and benefits associated with the treatment have been explained to me. I understand that this treatment may be discontinued at any time by either party. If I choose to refuse treatment, my therapist will determine other possible treatment options available including referral to another provider, if appropriate. If all appropriate treatment options are refused, I may be discharged from treatment.

I understand that as part of my health care, New Hope Counseling Services, P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, diagnosis, treatment and plans for future care or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment.
2. A means for communication among other health care professionals who contribute to my care.
3. A source of information for applying my diagnosis information to my bill
4. A means by which a third-party payer can verify that services billed were provided.
5. I understand that this information will be protected as explained in the HIPAA Notice of Privacy Practices, and I have been offered a copy of that Notice.

I understand that at times my personal therapist may be unavailable due to illness or vacation, and at those times a qualified therapist working with New Hope Counseling Services, P.A. will be made available for crisis services.

I agree to receive my service, if available, by telehealth if I am sick or have some other pressing need to not receive my services face-to-face. I understand there are risks associated with telehealth including lack of privacy and confidentiality in my setting, internet and technology may fail, an emergency may occur at my remote location, or telehealth may not be as effective for me. Whether or not this is an effective way for me to receive my services will be reassessed after each session.

_____ I consent to telehealth service or _____ I do not consent to telehealth services.

I further understand that New Hope Counseling Services, P.A. has a relationship with East Carolina University to allow students enrolled in the School of Social Work and School of Psychology to learn, under supervision, the practice or improvement of their skills in individual, group, joint or family counseling. The students may have access to my medical information for training purposes and are obligated to maintain full confidentiality in accordance with Title 42 Section 164.532(B) of the Code of Federal Regulations and the privacy practices of New Hope Counseling Services, P.A. By initialing here, I am indicating my consent or desire to withhold consent for students to participate/observe my treatment or to have access to my protected information at no penalty to me.

_____ I consent to student involvement or _____ I do not consent to student involvement.

I give permission to my clinician at New Hope Counseling Services to use AI software to transcribe my therapy session. I understand that the AI tool adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure my data is secured and protected. The transcripts are deleted after 30 days. Only your clinician will have access to the transcription. I understand that I can revoke my consent for the use of this software at any time and my participation is completely voluntary. This consent last for 12 months from the date of signature. By initialing here, I agree to the use of this software during my consultations.

_____ I consent to the use of AI software or _____ I do not consent to the use of AI software.

I understand that as part of New Hope Counseling Services P.A.'s treatment, payment, or health care operations, it may become necessary to disclose my protected information to another HIPAA covered entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and/or email transmission. I understand that my therapist has the right to seek emergency medical care from a hospital or physician on my behalf if deemed necessary.

Violation of Federal and/or State laws and regulations by a treatment facility or its providers is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State laws and regulations do not protect any information about a crime committed by a client, either at the New Hope Counseling Services, P.A. or against any person who works for the practice, or about any threat to commit such a crime. Federal laws and regulations require that any information about the suspected abuse or neglect of a child or vulnerable adult, or the abuse of an adult, be reported to appropriate state authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the organization's duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parent of a deceased client has a right to access their spouses or child's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non- emancipated minor clients have the right to access the client's records.

I further understand that New Hope Counseling Services, P.A. reserves the right to amend its notices and practices, and that upon implementation of these changes the client will receive notification of any such amendment.

I understand that I may refuse to sign this consent, and by doing so I may be denied treatment. I further understand that I may revoke this consent in writing at any time, except to the extent that the entity has already taken action.

I consent to treatment and agree to abide by the policies and agreements with New Hope Counseling Services, P.A., as stated above. This consent for treatment is valid for one year from the date signed below unless revoked by myself or responsible party.

_____	_____	_____
Signature of Client or Legally Responsible Person	Date	Expiration Date

_____	_____
Witness	Date