# Universal Consent

Client _____
DOB_____

**Language Service**_____(please initial)
I certify that I am English Speaking.

**Consent for Treatment**_____(please initial)
I hereby consent to the administration and performance of all tests and treatment by members of the personnel at Thrive Therapeutic Services (TTS) that in the judgment of the therapist may be considered necessary or advisable for the diagnosis or treatment for the condition for which I am presenting myself. I understand that the practice of therapy/ counseling is not an exact science and acknowledge that no guarantees have been made to me. I authorize TTS to request and receive information, including my client records, from my treating therapist(s) or agent.

**Release of responsibility for valuables**_____(please initial)
I acknowledge that TTS **WILL NOT** be liable for any loss or theft of any personal property of mine. I hereby release and exonerate TTS from any responsibility for loss or theft of my personal property.

**Assignment of insurance benefits and release of records**_____(please initial)
**Assignment:** I currently maintain insurance coverage which will reimburse the charges from TTS, my therapist and any services provide to me in consideration of those services, I hereby assign, transfer and convey to TTS all of my rights, title and interest in my insurance for reimbursement. **Release:** I herby authorize the TTS and any therapist who may treat me, to release pertinent information contained in my client record ( specifically: name, address, phone number, insurance plans, group numbers, employer identification, diagnosis(s), dates of service, duration of service, type of service, location of services, and providing therapist) to any billing agents, and third party payers responsible for payment of my charges including but limited to insurance companies, health benefits plans, employers involved and approval of benefits claims, governments agencies or intermediaries representing any of the above, for the purpose of billing and collecting for services rendered to me or on my behalf.

**Payment Guarantee**_____(please initial)
I hereby assume full responsibility for and agree to pay all cost, charges, and expenses incurred by me for the mental healthcare provided by TTS and/or my treating therapist, at the time of service, unless I qualify for financial assistance. If my medical insurance coverage is not to sufficient to satisfy such costs in full, my insurance is canceled, my insurance is changed, or I don't follow guidelines of my insurer and the resulting balance is not covered, I will be fully responsible for payment of the balance.

**Receipt of Notice of Privacy Practices** _____(please initial)

I acknowledge that I have received TTS Notice of Privacy Practices. I understand the notice describes the uses and disclosures of my protected health information by TTS and informs me of my rights with respect of my protected health information. For more information, contact the office at (847)749-3807.

**Receipt of TTS Financial Assistance Brochure**_____(please initial)

I acknowledge that I have received the TTS Financial Assistant Brochure. For more information, please feel free the contact the office at (847)749-3807.

Upon signing this consent, I acknowledge that I have read and understand the forgoing and accept its terms. I understand this will serve as consent for 1 full year from the date of signature, unless I submit a retraction of consent in writing.

Client Signature (18+)_____Date_____
OR Guardian Signature_____Date_____
Relationship to client **and** reason client is unable to sign _____