Krista Anderson Counseling
1710 N 144th St, Omaha, NE 68154- 402-706-1932

Consent to Treatment

I,_____(client, parent/guardian) authorize Krista Anderson, MS, LIMHP to provide _____ (client) with mental health services. I understand that these services may include individual, couples, family or group therapy, as well as psychological or chemical dependency testing, parent education, psychiatric services, and family support services. Treatment is not limited to these services and may include other services that may be considered appropriate or necessary to my treatment. I have the right to an explanation as to the nature and purpose of the services I receive and have my questions about these services answered at any time. I have the right to withdraw this consent to treatment at any time, either verbally or in writing. I understand that my mental health provider may want to discuss this with me, but that I reserve the right to stop treatment.

I attest that I am not receiving and will not receive individual, family, or couples therapy with any other service providers outside of Krista Anderson, MS, LIMHP, while I am receiving services through Krista Anderson._____(initial)

The information concerning my case is confidential and is not available to individuals or agencies without my written consent. There are a few instances in which information concerning my case may be required to be released without my consent. These instances are specified in the Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices.

By signing this form, I acknowledge that I have read and that I understand this consent, I have received the notice of privacy practices, and that any question I had prior to signing have been answered adequately by the staff/therapist signing below. Additionally, my signature indicates that I have been informed on the company's privacy practices and that they function in accordance with the Health Insurance Portability and Accessibility (HIPAA) Act.

_____ _____
Client's Signature Date

If Client is under 19 years of age the Parent/Legal Guardian must complete the information below.

_____ _____
Parent/Legal Guardian's Signature Date

_____
Relationship to Client

_____ _____
Staff/Therapist's Signature Date