Consent for Treatment

Assignment of Benefits and HIPPA Form Consent to Enter Treatment Your signature below will verify that you have read (or have had them read to you) the information contained here and that you asked questions about anything you do not understood up to this point. By signing, you freely acknowledge your willingness to undergo any treatment, counseling, testing and or diagnostic evaluation that may be deemed necessary by the clinicians at ProCare Wellness LLC. I understand that treatment is a joint effort between my providers/therapist and me, the results of which cannot be guaranteed. Progress depends on many factors, including motivation, effort, and other life circumstances. You also agree to enter a professional arrangement according to all business practices outlined in this agreement. You accept total financially responsibility for payment of all fees and services as described, regardless of insurance coverage or any other third-party payers. You will also be releasing ProCare Wellness LLC of any liability that directly or indirectly results from disclosure or exchange of any information covered in this agreement. At your request, a copy of this and any other document in your record that bears your signature will) be provided. You further understand that, upon request you will be provided with a written description of The Client's Bill of Rights and you have been appraised regarding the privacy of your medical records in accordance with the Health Insurance Portability and Accountability Act (HIPAA), a copy of both which has or can be given to me and is always available upon request. Finally, you understand, that you can end treatment at any time and that you can refuse any requests or recommendations made by the providers/therapist at ProCare Wellness LLC. Use of Electronic Mail (Email) Please be aware that email is not a form of therapy and does not replace a face to face therapy session, Emails may not be private or confidential, if you wish to communicate with the providers/therapist, we prefer you schedule an office appointment. Assignment of Benefits I authorize the release of medical information necessary to process this and all claims to the insurance companies including Medicare and Medicaid. I further request benefits be made payable to ProCare Wellness LLC.

Patient/Client Name Print: _____

Signature of Patient/Client: (Parent or guardian if minor child) _____

Date Witness Name/Title:_____

Witness Signature/ Date:_____