

609 Bryden Ave Suite B Lewiston, ID 8350 (208)816-8746

**Consent for Treatment/Acknowledgement Agreement Signature Form**

**Consent for Treatment**

Patients must give voluntary consent for mental health treatment. Your signature (or that of your legal guardian) will demonstrate consent for receiving mental health treatment from Mountain View Health PLLC. I voluntarily consent to mental health treatment as performed by the Mountain View Health PLLC and its employees. This treatment may include but not limited to: assessment, screening, consultation and recommendations, psychotherapy, holistic services and psychiatric medication management. I understand that mental health treatment may involve certain risks and benefits and I understand these risks and benefits. I also understand the risks and benefits of declining treatment. I am also aware that I have the right to request information about alternative treatment options, should they exist. I have read the above information and I authorize the Psychiatric Wellness Center to provide mental health services to myself or this patient (if guardian).

**Acknowledgement of Receipt of Mountain View Health PLLC Policies**

By signing this agreement, you agree that you have read the Mountain View Health PLLC Policies and you agree to abide by its terms during our professional relationship. Acknowledgement of Receipt of Notice of Privacy Practices We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish

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**Consent Form for Communication of Protected Health Information**

I CONSENT to the communication for appointment reminders via text, email or phone.

Cell phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other contact number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **I have carefully reviewed this document. My signature indicates my full understanding and agreement of this document.**

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient/parent/legal guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_\_\_/20\_\_\_\_

Witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_\_\_/20\_\_\_\_

For office use only: We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

□ The patient refused to sign

□ Due to an emergency, it was not possible to obtain an acknowledgement

□ We could not communicate with the patient

□ Other (Please provide specific details): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_