LAKE ORION COUNSELING CENTER
INTAKE ORIENTATION

I, _____, acknowledge that I was offered a copy of the Notice of Privacy Practices for Lake Orion Counseling Center, LLC (HIPAA-Health Insurance Portability and Accountability Act).

Additionally, I have had the general orientation regarding the following:

- Rights and Responsibilities Information including: Code of Ethics, Confidentiality Information, Grievance and Complaint Procedures, Privacy, and Crisis Intervention Information (additional information on website and in waiting area)
- Description of fee schedule, cancellation fee, and insurance participation.
- Treatment Service and Planning Participation, and hours of operation.

_____ Initial

Consent to Treatment

I hereby indicate that I am requesting to receive treatment at Lake Orion Counseling Center, LLC (LOCC). I understand that such treatment may consist of evaluation, psychotherapy, counseling and/or generally accepted treatments in the field of mental health or substance abuse and acknowledge my ability to be actively involved in my treatment. I am voluntarily authorizing treatment for myself or for my dependent at LOCC.
_____ Initial

Consent to Release Information to Mental Health Insurer

I authorize LOCC to release information for claims, certification/case management, quality improvement, and other purposes related to benefits of my health plan to my health care insurance provider. The information may include my mental health diagnosis, substance abuse, and/or HIV-AIDS status. I understand that this information may be required by my health care insurance provider in order for benefits to be applied. I understand that this authorization shall remain in effect for one year from the date of my signature below, or for the course of my treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to LOCC.
_____ Initial

Consent for Therapist to Share Client Information

I authorize LOCC to allow my information to be shared among LOCC therapists for training purposes. I understand I am under no obligation to do so and that I may revoke this permission at any time via written notice to LOCC.

_____ I authorize my therapist to share my case information with LOCC therapist peers
_____ I do not authorize my therapist to share my case information with LOCC peers.

My signature below indicates that I have read, initialed, and understand the above information:

_____ _____
Client/Parent or Guardian Date

_____ _____
Witness Date