JASON T. CERRO LPC, INC.
3175 Gold Star Highway
Unit 104, G3
Mystic, CT 06355
help@jasontcerro.com
401-524-5938

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Client: _____ DOB:_____

I consent to the use or disclosure of my protected health information (PHI) by JASON T. CERRO LPC, INC.for the purpose of providing services to me (or my child), obtaining payment for bills or services I or my child receive(s), or to conduct mental health care operations.

My protected health information means health information, including information that identifies me. It also means information that service providers have created about me and information that has been shared about me. This protected health information includes my past, present or future health conditions or services. It includes information that could be used to identify me even if my name is not used.

I have been provided a copy of the **Notice of Privacy Practices** for my review. These describe certain rights that I have under **The Health Insurance Portability and Accountability Act.** I have had an opportunity to ask any questions about my rights as a client of JASON T. CERRO LPC, INC.

I understand that JASON T. CERRO LPC, INC. can change the notice and the privacy practices.

I can obtain a copy of the change notice by contacting JASON T. CERRO LPC, INC. . I understand that the notice is posted at the office of JASON T. CERRO LPC, INC. in Mystic, CT.

I also understand that all treatment and evaluation with JASON T. CERRO LPC, INC. is voluntary and that I may cease treatment or evaluation at any time.

I also understand and give my informed consent to the provision of emergency medical procedures, including transport to and from treatment at a local general hospital emergency room should JASON T. CERRO LPC, INC. deem it necessary.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

JASON T. CERRO LPC, INC. is required by Federal Law to provide the attached notice and to prove that you received it. You may use your signature to indicate receipt.

I have read carefully and understand the content of this document and I consent for purposes of treatment, payment, and health care operations and I have been given a copy of the privacy notice.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent, Guardian, or Legal Representative Date

(If signing as legal representative, please describe your authority to act for this individual i.e. power of attorney, healthcare surrogate, etc.)_____