Pacific Northwest Recovery & Counseling
TMS Oregon
Liana Hategan MD PC

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

I, ___________________________________, give my authorization and consent to be counseled and treated by Pacific Northwest Recovery and Counseling. I acknowledge that the goal of treatment will be stated in my treatment plan and I will follow this treatment plan and participate in program activities and therapy as per program guidelines. The treatment will include; individual sessions, groups, and the Medical Provider. I allow the Practice to file for insurance benefits to pay for the care I receive.

I understand that:

● The Practice will have to send my medical record information to my insurance company.

● I must pay my share of the costs.

● I must pay for the cost of these services if my insurance does not pay within 30 days from the date of service or I do not have insurance.

● I understand: Insurance billing is a courtesy, and If my insurance does not pay in a timely manner(60) days I will pay Dr. Hategan

directly and have my insurance reimburse me for the claim.

● I have the right to refuse any procedure or treatment.

● I have the right to discuss all medical treatments with my provider.

This authorization and consent is given with my understanding that, although rare, there are potential risks associated with counseling (such as, uncomfortable thoughts, feelings, or information). Pacific Northwest Recovery and Counseling, by law, must report suspected ongoing child abuse, elderly abuse and plans of homicide or suicide. I understand the alternatives to this treatment may be referral to another agency, psychiatrist, or treatment facility. I hereby give my permission for Pacific Northwest Recovery and Counseling to give me medical treatment.

I have read and I understand this authorization and consent to treat form. This consent is voluntary and may be withheld or withdrawn at any time.

____ _______________________

Client Signature ***Date***

____ _______________________

Pacific Northwest Recovery and Counseling Witness ***Date***

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