Family Nest Counseling
1000 Market Street, Suite 41
Bloomsburg, PA 17815
570-204-7113
570-543-4962 Fax

Consent for Outpatient Treatment

I,_____, (parent/guardian name) agree and give consent to any examination, treatment, or therapy necessary or advisable for my child, _____to Family Nest Counseling. I understand that I may stop treatment at any time by giving written notice.

I realize that my child's treatment is confidential. Information may not be released without my written consent except if an issue were raised which, in the therapist's judgment, would endanger my child's welfare. I would be notified, as would appropriate authorities and resources, if indicated. My child's therapist may determine that my participation is needed to treat a specific problem for my child.

I understand that Family Nest Counseling may disclose and release all or any part of my child's medical record to any person or corporation which is or may be liable under a contract with Family Nest Counseling, or to the client or family member of the client for all or part of the Family Nest Counseling charges.

I hereby authorize payment directly to Family Nest Counseling for the services provided to my child. I understand that I may be financially responsible to Family Nest Counseling for charges and balances not covered by the insurance agreement.

If your child's health care is covered by Medical Assistance, I certify that the information regarding my child I have provided is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from Federal and State

funds, and that any false claims, statements, documents, or concealment of material facts may be prosecuted under applicable Federal and State laws.

I understand that I can phone and/or make an appointment with my child's therapist to discuss my child's needs, treatment plan goals and progress in treatment. Please feel free to contact the therapist at the number listed below.

Signature: _____

Relationship to the child:_____

Date Signed: _____

Please indicate if you want me to contact you personally about the treatment:

Yes_____ No_____

Best phone number and time to reach you: _____

You may also contact me any time at 570-204-7113