Looking Up Counseling Services, LLC

Consent Form

Client Name:		ID:	

Consent for Treatment

I understand the purpose and nature of the services recommended to me and I voluntarily consent to treatment by Looking Up Counseling, LLC (hereinafter referred to a LUC). This consent for treatment shall expire upon termination of services.

I consent to be contacted following discharge for purposes of obtaining information of assistance in efforts to improve the quality of care.

Client Handbook

I have received the client handbook. I have had its contents explained to me in language that I understand, including but not limited to: *Client Rights and Responsibilities*, *Notice of Privacy Practice* (HIPPA), Confidentiality AND *Exceptions to Confidentiality*, assigning a *Treatment Advocate*, *Grievance Procedures*, requesting copies of documents, terms of communication by text or email, and understanding *Telehealth Services benefits and limitations*. I understand additional copies of the Handbook are always available to me, free of charge.

I consent to communication by email, per terms in the Client Handbook	☐ Yes ☐ No
E-mail:	
I consent to communication by text, per terms in the Client Handbook	☐ Yes ☐ No
Phone number for text:	
I consent to surveys from LUC, per the terms in the Client Handbook	☐ Yes ☐ No
I consent to survey from The Oklahoma Department of Mental Health, per the terms in the Client Handbook.	☐ Yes ☐ No

Treatment Advocate

I would like to assign a Treatment Advocate	☐ Yes ☐ No

Financial

I assign all of my insurance benefits, to which I am entitled, to LUC in order to pay for my requested services. This agreement shall remain in effect until revoked by me in writing or when all third party claims are satisfied. I understand that my insurance will be utilized to pay for services received by me and in the event that I am no longer eligible for my insurance, I will make arrangements with the agency to continue services. I agree to fully cooperate with LUC in obtaining payment for services.

Fee Schedule Agreement: I agree to pay $______________ per session for the next six months of confirmed sessions.

With my signature, I understand the contents of this consent, understand the consent may be revoked at any time in writing and state that no guarantees or assurances have been given by anyone as to the results that may be obtained during treatment.

____

Date

Client Name:		Client Payer ID:	
Provider Number:		Date Completed:	

I/We (client/guardian) have actively participated in the development of this service plan and understand the treatment goals and objectives listed. I/We have the following response:

____

Client Signature, 14 or older Date

Parent/Guardian Signature Date

If client is unable to sign, document the reason: ______________________________

LBHP Signature indicates completion of the face to face assessment to determine medical necessity and appropriate level of care including the evaluation of all pertinent information by the other service practitioners and the member, and a review of the current service plan:

Responsible LBHP Signature, Degree/License Date

Case Manager Date

Type of Services	Frequency (week/month)	Staff Name & Credentials	Telehealth Consent