New Growth Counseling Services

430 E Lauridsen Blvd.
Port Angeles, WA 98362
360-457-1610

502 S Still Rd, Ste 102
Sequim, WA 98382
360-457-1610

Acknowledgment of Receipt

HIPAA NOTICE OF PRIVACY PRACTICES In signing below, you agree that you have had access our Notice of Privacy Practices. This Notice, among other points, explains how we plan to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. The Notice of Privacy Practices may change. A current copy may be requested by contacting our Privacy Officer at 360-457-1610 or visiting our website at www.thinknewgrowth.com. By signing this form, you acknowledge you have had access to, reviewed, and agree to our Privacy Practices and that New Growth Counseling Services can use and disclose your protected health information in accordance with HIPAA.

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Client (or parent/guardian of a minor) Date

CLINICIAN DISCLOSURE In signing below, you acknowledge that you have received and reviewed with the therapist the clinician's disclosure form and that you understand and agree to what is stated.

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Client (or parent/guardian of a minor) Date

OFFICE POLICIES DISCLOSURE In signing below, you acknowledge that you have received and reviewed with the therapist New Growth's office policies and that you understand and agree to what is stated. Including New Growth Counseling Services no show/late cancelation policy.

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Client (or parent/guardian of a minor) Date

CONSENT TO TREATMENT I have met with my therapist and have discussed with them the general focus and goals of therapy. They have explained to me, in general terms, the style of therapy we will be using and the possible length of treatment. I hereby give my formal consent to enter into therapy.

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Client (or parent/guardian of a minor) Date

FOR ALL CLIENTS USING INSURANCE OR EMPLOYEE ASSISTANCE PROGRAMS I authorize my insurance or employee assistance benefits to be paid directly to New Growth Counseling Services. **I am financially responsible for any balance due.** I authorize my therapist to release information regarding my diagnosis, the services provided, the dates that services were provided, and the cost of these services so that my insurance claim may be processed.

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Client (or parent/guardian of a minor) Date