

I Ola Lāhui, Inc.
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Informed Consent for Treatment/Authorization Form

Consent for Treatment

I hereby agree and consent to take part in treatment with my provider, and I understand that while I expect benefits from this treatment, results are not guaranteed. I understand that I have the right to refuse treatment and discontinue at any time without moral, legal or financial obligation. If I choose, I will be provided with referrals for other qualified providers within the community. If my provider is unavailable, I understand that every effort will be made to inform me in advance, and alternative coverage will be provided.

I understand that I will be advised of the risks of any unusual procedures, and I have the right to refuse unwanted therapeutic techniques. I have the right to refuse electronic media recording of any session and that this will not occur without my prior written consent. I understand the limits of confidentiality as they have been explained to me by my provider.

I have had the opportunity to discuss all the aspects of my treatment and have had my questions answered. I understand the parameters of treatment and understand the regular attendance will produce maximum possible benefits. I agree to comply with treatment planned.

Confidentiality

Behavioral health services are provided within I Ola Lāhui by providers with varying backgrounds, including pre-doctoral interns, post-doctoral fellows and licensed psychologists. Services rendered by paraprofessionals are supervised by their respective licensed provider(s). Your service provider should identify his or her professional status and clarify with you the nature of this, the individual providing supervision and discuss any concerns you may have regarding your care.

I understand records about my care will be kept in written or computerized form and will be available to all providers participating in my overall care and treatment. All providers within I Ola Lāhui insure confidentiality of the disclosed information by their patients within the limits outlined below. In most cases, your written consent must be obtained prior to the release of any patient information. There are, however, circumstances in which your provider may be required by law to disclose information pertaining to your treatment to

the authorities without your written consent. Your provider should inform you of such actions.

In general, the law protects the confidentiality of all communications between a client and a therapist, and the release of information to others about your therapy only with your written permission (see **Release of Medical Records**). However, there are exceptions where:

- Client is a danger to self / others
- Abuse or neglect of a child, elderly or disabled person
- Specific court cases or proceedings

Release of Medical Records

Authorized release of your medical records to other entities requires written consent in the form of a Release of Medical Records. However, in order to ensure proper follow-up and continuity of care, I agree that a brief summary including the nature and length of treatment may be released to my referring provider.

Insurance Authorization

I request that payment of authorized benefits be made to I Ola Lāhui on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third-party payer, state medical assistance agency, or any other government or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all the charges not covered by a third-party payer. I authorize a copy of this authorization to be used in place of the original.

I have read the above and understand the nature of services provided, the limits of confidentiality and release of my medical records, and charges for services.

Name of Patient: _____

Signature of Patient/Parent/Guardian: _____ Date: _____

Psychologist Signature: _____ Date: _____