2503 West Broad Street
Columbus, Ohio 43204
www.moment2momentllp.com
(p) 614.678.8585 (f) 614.516.0710

Authorization for Services

I have read and understood the Client Guidelines (the Agreement) and have been given a copy for myself. I understand my rights and responsibilities and those of the clinician. I have read and understand the above and authorize the disclosure of name identifying billing information to the Ohio Department of Human Services, and MITS (Medicaid Information Technology System).

I agree to the conditions of this Agreement and give my informed consent and authorization for the following service(s) and location (s) for myself:

Services:
[ ] Individual Psychotherapy
[ ] Therapeutic Behavioral Services

_____
Client's Signature

_____
Client's Printed Name Date

I agree to the conditions of this Agreement and give my informed consent for the above service(s) and location(s) for the minor child/adult ward. I understand that the conditions of this Agreement apply to the child/adult ward and as parent/legal guardian I can consent to release information about the child's treatment.

_____ _____
Guardian's Signature Date

Client Rights Statement

I have read and understand the Client Rights Statement and have been given a copy for myself.

Client's Name: _____

Client's Signature: _____

Parent/Legal Guardian's Signature: _____

Staff Representative's Signature: _____

Date: _____

Privacy Notice Acknowledgment

I acknowledge that I have been given a copy of Moment to Moment LLP's "Privacy Notice" and understand these rights and responsibilities. I understand that if I have any questions about these issues that I can discuss them with my clinician.

_____
__ Client Name

_____ _____
Client/Guardian Signature Date: