

Integrative Therapy Institute of NJ

Informed Consent Form

I hereby authorize the Integrative Therapy Institute of NJ (ITINJ) to disclose information from my records relating to my treatment in order to obtain insurance reimbursement. I understand that I may review this information and that I may revoke this consent by letter at any time.

YES: ____ NO: ____ INITIALS: ____

I acknowledge that I have reviewed or received a copy of the HIPAA/Privacy Policies of ITINJ that pertain to my personal and medical information.

YES: ____ NO: ____ INITIALS: ____

I acknowledge that I have reviewed a copy of the Financial Agreement.

YES: ____ NO: ____ INITIALS: ____

I hereby give permission to ITINJ to provide psychological treatment to:

_____. The person receiving treatment is (please check one):

Myself: ____ My child: ____ Other: (please explain) _____

I understand that I may revoke this consent by letter at any time. I also understand that the confidentiality privilege of a minor belongs to his or her guardian, but that minors who are age 14 (fourteen) or older have the same confidentiality rights as adults.

YES: ____ NO: ____ N/A: ____ INITIALS: ____

Signature of a child (if applicable): _____

Print Name: _____

Signature: _____

Date: _____