Gathering Precious Stones, LLC
Counseling and Assessment Services

Authorization for Treatment & Services

Client's Name: _____________________ DOB: _______________________

Parent's/Guardian's Name: __________________ Date: _________________

I am requesting services by Gathering Precious Stones, LLC. I apply for and consent to medical, counseling, and psychiatric services from a Physician and/or Staff from Gathering Precious Stones, LLC and its components programs.

A report or reports concerning the counselor's findings will be available, as requested by, probation, court, guardian, and/or social services. Progress in the Client's treatment will be reviewed every 30 days. The guardian will sign a release before any information can be released. Information about me related to my services from Gathering Precious Stones, LLC. is confidential and may be privileged. Information is shared with staff involved in my care only on a need to know basis. It cannot be disclosed to a third party without my express consent except under special circumstances that include the following: information about physical or sexual abuse, exploitation, neglect, or deprivation of a child or incapacitated adult will be reported as required by law. Gathering Precious Stones, LLC. will exercise its duty to warn other individuals if I threaten physical harm to them; if I threaten physical harm to myself. Gathering Precious Stones, LLC. will exercise its duty to care and will take reasonable steps to protect me. When a court of legal jurisdiction issues a proper subpoena or order, the information specified may be submitted to a court of law. Limited information may be provided to law enforcement serving an arrest warrant or investigating a crime.

I agree to provide accurate and completed information for the appropriate billing for Client's treatment, and I agree to update this information as changes occur. I understand that I will not receive a bill from Medicaid for my participation in Core Services. However, the participation in Core Services will be reported for billing purposes.

I agree to work toward the goals and objectives as established in the Individualized Recovery/Resiliency Plan. The IRRP's contains goals and desired outcomes that are reasonable and attainable for discharge to less intensive community supportive services.

The Client and guardian have been explained the above statements and questions where appropriate.

______________________________ ______________________________
Client Signature Date

______________________________ ______________________________
Parent's/Guardian's Signature Date

______________________________ ______________________________
Witness's Signature Date