Legacy Clinical Consultants, LLC

Transforming Lives, Impacting the Future

Consent Signatures

Client Name: _____

Notice of Privacy Practices Acknowledgment

I hereby acknowledge I have been given an opportunity to read a copy of **Legacy Clinical Consultants' *Notice of Privacy Practices*** which details how my health information may be used and disclosed under federal and state law. The Notice also outlines my rights regarding my health information. I understand if I have any questions regarding this notice of my privacy rights, I may contact the Privacy Officer at 630.527.1664 or 815.577.3666.

Consent for Treatment

I hereby acknowledge I have read and understood the **Professional Disclosure Statement** and the **Financial Policy** and I voluntarily consent to treatment under these conditions.

_____ _____

Signature of Client *(Age 12 and older)* Date

_____ _____

Signature of Parent, Guardian or Personal Representative Date

☐ **Client refuses to acknowledge:**

_____ _____

Signature of Staff Member Date

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