

Alexandria L. Westfall, MA
Licensed Psychological Associate
115 Market Street, Suite 360-F
Durham, NC 27701

1. Consent for Treatment

I hereby give my consent for Alexandria L. Westfall, MA, LPA to provide mental health services to me/my child. I have been informed of the scope and purpose of the service, and understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time.

Client/Guardian: _____ Date: _____

2. Consent for the Disclosure of Information Pertaining to Substance Abuse

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been

Client/Guardian: _____ Date: _____

3. Financial Release

I further understand that Alexandria L. Westfall, MA, LPA may use confidential information about me/my child to bill and be paid for services. I hereby consent for Alexandria L. Westfall, MA, LPA to release information to the funding source (referring area program): Alliance Behavioral Healthcare & Medicaid and for (referring area program): Alliance Behavioral Healthcare & Medicaid to release information to Alexandria L. Westfall, MA, LPA for this purpose.

Medicaid #: _____

Card witnessed: Yes No

Other insurance carrier: _____ ID #: _____

Client/Guardian: _____ Date: _____

4. Permission to Transport

I hereby grant permission for Alexandria L. Westfall, MA, LPA provider, to provide transportation for me/my child, and agree to hold Alexandria L. Westfall, MA, LPA harmless for any accident/injury that results from the provision of transportation.

Client/Guardian: _____ Date: _____

CLIENT NAME: _____
MEDICAID ID: _____

MR#: _____
DOB: _____

5. Permission to Seek Emergency Medical Care

I hereby give consent for Alexandria L. Westfall, MA, LPA provider to seek and sign consent for emergency medical care in the event that I am unable to do so for myself/my child. It is understood that the Alexandria L. Westfall, MA, LPA provider will attempt to locate me, or another legally responsible adult, as quickly as is possible in the emergency situation.

Client/Guardian: _____ Date: _____

6. Client Rights/Grievance Policies (See Handout)

I have received the Alexandria L. Westfall, MA, LPA Client Rights handout. Alexandria L. Westfall, MA, LPA provider gave me this handout and verbally explained my/my child's rights as Alexandria L. Westfall, MA, LPA client. I understand my right to file a grievance with Alexandria L. Westfall, MA, LPA Director of Operations if I am unhappy with the care provided to me/my child or decisions made by others regarding my/my child's care.

Client/Guardian: _____ Date: _____

7. Privacy Rights (See Handout)

I have received the Alexandria L. Westfall, MA, LPA Privacy Rights handout. Alexandria L. Westfall, MA, LPA gave me this handout and verbally explained my/my child's rights concerning the privacy of information as Alexandria L. Westfall, MA, LPA client. I understand these rights are designed to protect my/my child's privacy while receiving Alexandria L. Westfall, MA, LPA services.

Client/Guardian: _____ Date: _____

Agency USE ONLY

I, Alexandria L. Westfall, MA, LPA, have explained and provided copies of the following: Client Rights/Grievance Procedure Handout; the Privacy Rights Handout; Acknowledgment of Criteria and Procedures for Discharge; Acknowledgment of Access to First Responder System; and the Service Description to the Legal Guardian/ Client.

Signature: _____ Date: _____