EMPOWER

Therapeutic Support Services LLC

227 Colfax Ave N Ste 15
Minneapolis, MN 55405

Authorized Consent to Treatment and Payment
Acknowledgement of Receipt of Notice of Privacy Practice

Name of Individual: ____Date:________________

Individual Name (or Legal Representative):____

Individual's (or Legal Representative's) Signature:____________________________________

Please initial 1-3, which corresponds to your signature above to indicate understanding and consent:

_______ I acknowledge receipt of a copy of Empower Therapeutic Support Services, LLC Notice of Privacy Practice.

_______ I understand the service that will be provided and consent to treatment.

_______ I hereby authorize payment directly to Empower Therapeutic Support Services, LLC of the policy benefits otherwise payable to me, but not to exceed the provider's regular charges for the period of treatment. I understand that I am financially responsible to ETSS for all charges not covered by this authorization.

For Office Use Only

We made the following efforts to obtain written acknowledgement of receipt of the *Notice of Privacy Practices:*

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However, acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify):

Received by: ____
(Staff)