Prairie Wellness

3209 Ingersoll Ave, Suite 100
Des Moines, IA 50312
Phone: 515-207-1705
Fax: 515-993-3845
info@prairiewellness.com
www.prairiewellness.com

Your signature indicates that you have been offered a copy of the Prairie Wellness Notice of Patient Rights, Responsibilities, Treatment Expectations, and Consent to Treatment, which outlines your rights and responsibilities and Prairie Wellness' treatment expectations, emergency services, financial policy, hours of operation, and grievance and termination of services procedures. Your signature indicates that you understand Prairie Wellness has the right to revise these information practices. A revised Notice will be posted online at www.prairiewellness.com and you may obtain a current Notice at any time.

Your signature indicates that you have been offered a copy of the Prairie Wellness HIPAA Privacy Notice.

Your signature indicates you consent to be treated by a Prairie Wellness therapist.

Your signature indicates that you consent to Prairie Wellness releasing information to your insurance company for billing and auditing purposes and to submit insurance claims on your behalf, if you are using insurance to pay for your therapy sessions.

_____

Printed Name of Client

_____ _____

Signature of Client Date

_____

Printed Name of Parent / Legal Guardian (if applicable)

_____ _____

Signature of Parent / Legal Guardian (if applicable) Date

_____

Printed Name of second Parent / Legal Guardian (if applicable)

_____ _____

Signature of second Parent / Legal Guardian (if applicable) Date