



**MINDFUL HEARTS THERAPY**  
**7702 E. Doubletree Ranch Rd., Ste 300**  
**Scottsdale, AZ 85258**  
**520-329-7955 VLP4102@aol.com**

This form is an agreement between, \_\_\_\_\_ and Mindful  
Hearts Therapy. When I refer to the word “you”, it can apply to you, your  
child, a relative, or other person if the name is written

here \_\_\_\_\_.

When I examine, test, diagnose, treat, provide services, or refer you to another provider, I will be collecting what the law refers to as Protected Health Information (PHI). I will use this information to decide on treatment/ services to provide and to be able to provide you treatment/services. I am also able to use and share this information with others who provide you treatment or to arrange payment for the treatment/services I provide or other business/government functions.

By signing below, you agree to let me use this information here and send it to others such as your insurance company. The Notice of Privacy Practices explains in more detail your privacy rights and how I can use and disclose your information. Please make sure to read this notice before signing this Consent form. In the future, I may change how I use and share your information so I may change our Notice of Privacy Practices. If I do so, I will provide you an update copy. If you are concerned about some of your information, you have the right to ask me not to share some of your information for treatment, payment, or administrative purposes and will need to tell me what you want in writing. I will try to accommodate your requests; however, I am not required to agree to these limitations, but if I do agree, I will honor our agreement unless I are unable to by law.

After you have signed this request, you can revoke your consent by writing a letter to me informing me of your wishes. I will comply with your request from that point forward but will be unable to change or revoke the information that has already been shared. Please be aware that if you revoke your consent, I will be unable to continue providing treatment or services to you.

**If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, I cannot treat you.**

\_\_\_\_\_  
Signature of client or personal representative      Date

\_\_\_\_\_  
Signature of client or personal representative      Date

\_\_\_\_\_  
Relationship to Client/Description of personal representative's authority

\_\_\_\_\_  
Signature of Therapist      Date

\_\_\_\_\_ I HAVE BEEN GIVEN A COPY OF THE NPP  
Client initials