Patient
Name:
DOB:
MR #:

Index to Consent – Treatment/Procedures – Behavioral Health

Date: _____

I understand that I may have a behavioral health condition that may require treatment. I consent to the proposed evaluation and/or treatment provided at Associated Physicians, LLP – Behavioral Health. I understand that the services available to me may include but are not limited to:

- evaluation,
- diagnosis,
- treatment planning,
- individual and group counseling,
- medicine,
- family counseling,
- education, and
- treatment discharge planning and referral.

I understand how the services are provided. When possible, my behavioral health provider will discuss other treatment options with me. This could include referrals to other providers, alcohol and/or drug treatment, information on community resources, or other options.

I have been given the information to verify my benefits and prior authorization needs for these services. I agree to notify Associated Physicians, LLP of any prior authorization or benefit requirements needing to be done before my appointment for coverage, otherwise I may be responsible for the charges.

☐ ***(Checking this box means you agree to these terms above)***

Risks and Benefits

I understand that there are potential risks and benefits of participating in a program for behavioral health treatment.

Benefits may include but are not limited to:

- improved quality of life,
- fewer psychological symptoms,
- reduced health risks and medical problems,
- improved family, social and employment relationships.

Risks may include but are not limited to:

- Medication related side-effects,
- anxiety related to making life changes,
- effects on personal relationships, and
- others' negative perceptions about mental health treatment.

There are some likely consequences of not receiving behavioral health treatment. These may include but are not limited to:

- psychological distress,
- decreased life satisfaction,
- impaired employment, and
- a negative impact on relationships.

Associated Physicians, LLP

BEHAVIORAL HEALTH INFORMED CONSENT TO TREATMENT

Privacy Rights

Your right to privacy is important to us. State and federal laws and our high ethical standards require that we keep patients' health information confidential. Laws also limit the ways we can use and share that information. Information about your behavioral health condition(s) and/or treatment may be shared with other Associated Physicians or outside health care providers involved in your care as necessary for your continuing treatment. Your physical and mental health affect each other; sharing information with all of your health care providers allows them to best meet your health needs.

Associated Physicians may also share information as necessary for purposes of payment and health care operations, and as otherwise allowed by state and federal law. More details about how Associated Physicians, LLP may use and share your health information is contained in the Notice of Privacy Practices. A copy of this was provided to you. The Notice of Privacy Practices is also on the Associated Physicians, LLP website at https://www.apmadison.com/privacy-policy.

I understand my rights, including my right to withdraw my consent in writing at any time. I have been offered a copy of those rights. I understand the clinic's grievance procedure and have been offered a copy.

I have read and understand all of the information given to me. I have been given enough time to ask questions or get more information and to get answers to my questions. The risks and benefits of the treatment and other treatment options have been made clear to me. I have been told what may happen if I do not have treatment. The information provided to me is specific, accurate and complete. I consent to evaluation and treatment at Associated Physicians, LLP – Behavioral Health. This consent expires 15 months from the date of my signature below, upon my discharge from treatment, or when I give written notice that my consent is terminated (if earlier than 15 months from the date of my signature).

I may request and receive a copy of this consent.

AUTHORIZING SIGNATURES:

Signature of Patient/Representative_____Date:____/____/____Time: _____
If signed by person other than the patient, print name and state relationship and authority to do to.

Print Name:_____Relationship: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor
☐ Health Care Agent ☐ Other: _____

Provider Signature:_____Print Provider Name: Gil Roth, LCSW, SAC

Date:____/____/____Time:_____

_____ _____
Interpreter or Reader Signature (if applicable) Witness Signature*

_____ _____
Print Interpreter or Reader Name Print Witness Name

____/____/____ _____ ____/____/____ _____
Date Time Date Time

* Only required if patient signature not obtained by physician or when telephone consent obtained.