Name of Client (Print): ____Date of Birth: _______________

Informed Consent for Behavioral Health Treatment

Consent to Services: I voluntarily consent that I will participate in a behavioral health treatment (e.g. psychological or psychiatric) by staff from the Cognitive Behavior Institute; Psych-Med Associates; Jennifer Almendrala MD, LLC; Peter Murray MD, LLC; and/or Blackbird Health, LLC. Treatment may be provided by a licensed counselor, a psychologist, a psychiatric nurse practitioner, a psychiatrist, or an individual supervised by any of the professionals listed. Services may include interviews, assessment or testing, psychotherapy, and/or medication management.

Risks & Benefits: Behavioral health treatment has both benefits and risks. Risks may include experiencing uncomfortable feelings because the process often requires discussing difficult aspects of one's life. However, treatment has been shown to have benefits. It often leads to a significant reduction in feelings of distress, increased satisfaction in relationships, greater awareness and insight, increased skills and resolutions to specific problems. A small number of clients may not improve because of treatment or may terminate before it is clinically indicated. It is important to keep your clinician advised of any difficulty you may encounter during your treatment.

Person Financially Responsible for Account: The undersigned hereby agree to be financially responsible for this account.

Name: ______________________________________ DOB: ____________

Address: ____

Home Phone: __________________Work Phone: ___________________Cell Phone:_________________

Email Address: ____

Insurance Information: Please complete and provide a copy of your insurance card to office staff.

Name of Policyholder**_______________________________*****Policyholder DOB:*****_______________________**

Member ID **____________________________________*****Group Number*****_______________________________**

Name of Insurance**_________________________*****Phone Number of Insurance*****_______________________**

Secondary Insurance Information: *(if applicable) Name of Insurance:* _____________________________

Name of Policyholder**_______________________________*****Policyholder DOB:*****_______________________**

Member ID **____________________________________*****Group Number*****_______________________________**

Name of Insurance**_________________________*****Phone Number of Insurance*****_______________________**

Credit Card Information: In accordance with our Financial Obligation Policy, please complete the information below in. This information is kept secure in our electronic client Vault.

Name on Credit Card ____

Card Number ____________________________Exp Date ______________CVV Code(on back)____________

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Name of Client (Print): ____Date of Birth: ______________

Did you receive a referral through an Employee Assistance Program (EAP)? Yes ____ No ______

Name of Employer: _______________________________________

EAP Name: _______________________________________

EAP Phone Number: _______________________________________

Authorization Number: ______________________________________ Number of Sessions: __________

<u>Emergency Contact:</u> Please provide contact information for someone we may contact on your behalf.

Name: ____ Phone Number: ____________________

Relationship to Patient: ____

Name: ____ Phone Number: ____________________

Relationship to Patient: ____

<u>Expiration of Consent:</u> This consent will expire at the time of discharge from behavioral health services from the Cognitive Behavior Institute.

<u>Attestation of Informed Consent</u>: Information regarding our policies and procedures is provided as part of this informed consent. Please review these documents carefully and **initial below**. Your initial indicates that you have read, understand, and agree to the information provided in each of the policies and procedures.

I have read, understand and agree to the Medication Management Agreement. ___________

I have read, understand agree to the Electronic Communication Policy. ___________

I have read, understand and agree to the Client Rights & Responsibilities. __________

I have read, understand and agree to the Notice of Privacy Practices. ___________

I have read, understand and agree to the Financial Obligation Policy. ___________

I have read, understand and agree to the Distance Counseling Procedures. ___________

I have read and understand the above information, have had an opportunity to ask questions about this information, and I consent to behavioral health treatment through the Cognitive Behavior Institute as outlined above. If applicable, I also attest that I am the legal guardian and have the right to consent for the treatment of this minor.

____

Signature of Legal Guardian (if client under age 14) Date Print Name

____

Signature of Client Date Print Name

____

Signature of Additional Client(s) (if appropriate) Date Print Name

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