AREA MENTAL HEALTH CENTER

VOLUNTARY INFORMED CONSENT FOR TREATMENT

Client Name: ____
Client Address: ____
Client Date of Birth: _____/_____/_____ Client Social Security Number: _________________

I understand that by signing this consent for an initial assessment and treatment that I am agreeing to participate in a mental health intake assessment at the Area Mental Health Center. The purpose of this assessment is to evaluate my current mental health needs and to develop specific assessment recommendations related to my concerns that have brought me to the Center.

I understand that the initial assessment will be conducted by an Area Mental Health Center master level therapist. The assessment will consist of interviews between that therapist and myself. Psychological testing may be recommended to more thoroughly evaluate my needs. Some mental disorders can have medical or biological origins and may require a consultation with a physician.

I understand that the practitioner may need to discuss my case in a confidential manner with a professional treatment team and/or supervisor for the purpose of providing quality service. I am aware that additional professional staff may be asked to participate in the evaluation and treatment. I understand that these discussions will be kept confidential unless I authorize that information be released or unless allowed or required by law. These exceptions to confidentiality are referenced in the Client Rights and Responsibilities Brochure of which I have been given a copy. **By signing this form I am also acknowledging that I have received a copy of the Client Rights and Responsibilities Brochure. I hereby consent to participate in the process of my assessment and treatment at the Area Mental Health Center. I have received AMHC's Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA).**

I understand that some treatment recommendations may be addressed during the initial interview(s). Once the assessment is complete and an initial treatment plan has been formulated, I will be given the opportunity to review and discuss with the practitioner the results of the assessment, the nature of the condition, and any treatment, including alternatives to these recommendations.

I understand that this consent is voluntary and that I can withdraw my consent to treatment at any time.

____ _______________
Client Signature *Date*

____ _______________
Witness Signature *Date*