CONSENT FOR BEHAVIORAL HEALTH SERVICES

This consent applies to myself, those under my legal guardianship or client named below. Since I have the right to refuse services at any time, I understand and agree that continued participation implies voluntary informed consent.

I understand that the potential benefits of receiving behavioral health services may include obtaining a professional opinion. I understand that all staff of Barrington Behavioral Health & Wellness (BBHW) may consult and collaborate on cases where therapeutically appropriate. I understand that all BBHW staff are bound to the same standards of confidentiality as indicated herein.

I understand these services will be billed to Medicare and any supplemental insurance.

I understand that I am responsible for all charges, regardless of insurance coverage. In the event your account is over 120 past due your account may be turned over to a collection agency.

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist below. A photocopy of this assignment is to be considered as good as the original.

I understand and agree that disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below:

1. Where abuse or harmful neglect or children, the elderly, or a disabled or incompetent individual is known or reasonably suspected
2. Where the validity of a will of a former patient is contested
3. Where such information is necessary for the practitioner to defend against a malpractice action brought by the client
4. Where an immediate threat of physical violence or suicide against a readily identifiable victim is disclosed to the practitioner
5. Where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue
6. Where the client is examined pursuant to a court order

I hold harmless for releasing information under the above conditions.

I hold_____ harmless for releasing information under the above conditions.
(BBHW Clinician)

Clients Name: _____ Date of Birth: _____

POA Name: _____

POA Signature: _____ Date: _____

Facility: _____

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