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 **INFORMED CONSENT FOR ASSESSMENT AND TREATMENT**

I understand that I am eligible to receive a range of services at ViaQuest. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me.

I understand that all information shared with the clinical staff at ViaQuest is confidential and no information will be released without my consent. In most circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically

bound to take necessary steps to prevent such danger.

B. When there is suspicion that a client is being sexually or physically abused or is at risk

of such abuse, the clinician is legally required to take steps to protect the client, and to inform the

proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound

by law to comply with such requests.

I understand that a range of mental health professionals, some of whom are in training, provides services. All professionals-in-training are supervised by licensed staff. I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.

I agree to the following:

\_\_\_\_\_\_\_ I authorize ViaQuest to bill my insurance and release pertinent information to my insurance carrier. I understand that I am liable for all co-pays, deductibles, and any fees unpaid by insurance for any reason and am responsible for understanding my benefit plan. Additionally, I understand that ViaQuest has no contractual obligation with my insurance company or me that would entitle or guarantee me reimbursement for expenses I incur for services at ViaQuest.

\_\_\_\_\_\_\_ I agree to pay a self-pay rate of $\_\_\_\_\_\_\_\_\_per hour of service. I understand that payment is due at time of service for all fees.

If I have any questions regarding this consent form or about the services offered at ViaQuest, I may discuss them with clinical staff. I have read and understand the above. I understand that I may stop treatment at any time and that this consent expires 1 year from date signed. I consent to participate in the evaluation and treatment offered to me by ViaQuest.

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_