ASPIRE NETWORK

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Receipt of Informed Consent for Mental Health

Services are being requested for:

Name of patient: _____ Date of birth:_____

By signing this consent for treatment, I am attesting to the following:

* The nature and purpose of treatment, possible complications, possible alternatives, risks involved, and possible consequences have been explained to me and I consent to treatment.

* I understand that there is no guarantee or assurance given to me by anyone regarding the results of treatment.

* I have been given a copy of the Informed Consent for Mental Health Services and have been given the opportunity to ask questions.

* I have also been informed ofTelehealth and give my consent to participate in telehealth if I am unable to do face-to-face sessions.

* I give permission to Aspire Network to provide information to my insurance company for the purpose of payment for the treatment/service provided. This may include contacting the insurance company to check coverage, to tell them about any diagnoses, what treatments have been received, dates of service, progress, and other similar things.

By checking the boxes below, I acknowledge receipt of the following information.

☐ I affirm that I reviewed the HIPAA Notice of Privacy, Confidentiality, Rights, and Procedures

☐ I am aware that my participation is voluntary and I can choose to end services at any time by informing my ARMHS Practitioner.

☐ I consent to telehealth services in the event that services cannot be conducted in person

☐ I reviewed and understand the cancellation policy

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND AGREE TO THE TERMS OF THIS AGREEMENT.

Signature of client: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Staff Signature: _____