**Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Keystone Mental Health**

**Consent to Services / Rights Acknowledgment**

**CONSENT TO SERVICES**

I hereby request and consent to services for myself/dependent which includes therapy, diagnostic assessment, case coordination, consultation, and other treatment/services recommended by Keystone Mental Health. I understand that psychotherapy often involves discussing unpleasant aspects of your life, which may lead to uncomfortable feelings of depression, sadness, anger, helplessness. On the other hand, psychotherapy has been shown to reduce the amount of distress someone is feeling, improve relationships, and/or resolve specific issues, but there are no guaranteed outcomes. I understand playing an active role in the therapeutic process and attending all scheduled appointments is in my best interest.

I am also aware that I may stop treatment with my therapist at any time. I understand if I choose to terminate services, I will still be responsible for paying for any services, I have already received. I understand I may experience increased mental health symptoms, due to early termination/none completion of mental health services.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatment I receive at Keystone Mental Health. I understand if payments for the services received at Keystone Mental Health are not rendered, my services will be terminated.

I have been informed that any information regarding services at Keystone Mental Health are subject to release only by my informed and written consent or by subpoena and/or court order. I have also been informed that patient identifying information about me may be exchanged between office staff and other designated/contracted providers for continuity of care purposes.

I authorize Keystone Mental Health to release any information necessary to process claims for the services provided. I authorize payment of governmental/medical benefits to Keystone Mental Health for services provided. I understand I am responsible for any and all charges not met by my insurance company.

I understand and agree to the terms of the Consent to Services/Rights Acknowledgement policy.

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Client Signature (Client’s Parent/Guardian) Date