

# Consent for Behavioral Health Services

Please review and initial each of the following statements below regarding your behavioral health treatment and services as provided by AID Atlanta.

My initials on each item below represent that:

\_\_\_\_ I am giving my voluntary consent to receive counseling and mental health services as provided by my AID Atlanta Behavioral Health Therapist.

\_\_\_\_ I have been informed that my participation in these services is voluntary and that my consent may be withdrawn at my discretion.

\_\_\_\_ I have been informed that behavioral health treatment is not an exact science and that my active participation is necessary for best results.

\_\_\_\_ I understand that, with some problems, it is not uncommon to feel worse before feeling better. As a result of therapy, people may make significant changes in emotions, attitudes, beliefs, behaviors, jobs and relationships. No specific treatment outcome can be promised or guaranteed.

\_\_\_\_ I have been informed of the following limitations on confidentiality that my provider must observe regarding safety of self or others: My provider is responsible for assessing safety risk associated with suicidal/homicidal ideation; depending on this risk assessment, my provider has a "duty to warn" others who are in harm's way and/or take action to achieve a safe environment for the individual; additionally, my provider is required by law to release information in cases of abuse to children or the elderly.

\_\_\_\_ I have been informed that my treatment will be provided within the scope of my provider's licensure, certification, and training.

\_\_\_\_ I will be informed in the event that my mental health needs are beyond the scope and practice of my provider's qualifications. If my needs are found to be beyond the scope and practice of my provider's qualification, appropriate referrals will be made.

\_\_\_\_ I have been informed that my Therapist will endeavor to return calls as soon as possible; however, if you are experiencing a mental health emergency, either call 911, the GA Crisis and Access Line (1-800-715-4225), or go to a hospital emergency room.

Your signature below indicates that you have read and agree to the statements above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_