IMPACT BEHAVIORAL HEALTH
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Tallahassee, FL 32308
www.impactbehavioralhealth.com
Scheduling: (850) 671-4600 Fax: (850) 878-2863

INFORMED CONSENT FOR TREATMENT

I hereby request that I, _____,
(Name)
born _____, be accepted for mental health and/or alcohol and drug
(Date of Birth)
abuse treatment by Impact Behavioral Health. By my signature below, I agree to the

following statements.

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from Impact Behavioral Health.
2. I have been given information regarding my rights and responsibilities as a patient.
3. I have been given information regarding the limits of confidentiality of my records.
4. I have been given information regarding the cost of services. I understand that I may be responsible to pay a co pay and that it is payable each time I come for treatment.
5. I understand that I may address any concerns or grievances with my therapist at any time. I understand that I may also contact the licensing board, which regulates my therapist's professional practice.
6. I am freely choosing to enter into treatment, and I understand that I may discontinue at any time.
7. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives.

_____ _____
Signature of Patient or Parent/Guardian Date

Parent or Guardian:
I, _____, do hereby state that I am the natural parent or legal guardian of the patient; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

_____
_____Signature
Date