INTAKE CONSENTS

Client Name: ____ Date of Birth: ______________________

(If client is a minor) Parent/Legal Guardian Name: ____

CONSENT FOR TREATMENT AND TREATMENT LOCATION: I consent for my child/myself (individual 'Client' named above) to participate in mental health assessment and treatment through IMPOWER at any IMPOWER office and the following locations:

1. ____

2. ____

3. ____

I also consent for the following individuals/organizations to be involved in the treatment of the above-named client. I understand that these persons will need to have access to protected health information for the purpose of assessment, treatment and health care operations.

1. Referral Source

2. ____

3. ____

4. ____

Consent to Receive Telehealth Services

I consent for the individual named above to receiving behavioral health services via telehealth. I have been informed of my diagnoses and proposed telehealth treatment plan. I understand that the individual named will be receiving health care services through an interactive, secure, web-based platform through the internet.

I understand that I will be oriented to the equipment and process before the initiation of telehealth services. I understand that my child's or my participation, at any time in telehealth, is voluntary and I may refuse to participate or decide to stop participation at any time. I understand that my refusal to participate or decision to stop will be documented in my medical record.

I understand that the privacy and confidentiality of individual named above will be protected at all times. I also understand that the likelihood of a videoconference being intercepted by an outsider is similar to the potential interception of a phone call. When I am receiving services via telehealth, I will be notified as to who is in the room at the remote site.

I understand that the health care providers at both my child's/my location and the remote video site will have access to any relevant medical information about my child/me including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records.

I further consent for the sharing and use of information for medical care, research, and collaboration with treating & research clinicians.

INFORMATION MAY BE SHARED WITH OTHER IMPOWER PROGRAMS.

PRIVACY EXCEPTIONS: In some circumstances, we are required to report private information about your child or you. We have a duty to report suspicion of child abuse and neglect to the State of Florida. We have a duty to warn potential victims if we believe that their lives are in danger. Other exceptions to privacy are explained in the Privacy Notice.

FUNDING AUTHORIZATION: I authorize my funding agency to pay for services directly to IMPOWER. I understand that I will be responsible for the charges that this funding source does not cover. I further understand that protected health information will need to be released to the above-named funding source in order to process claims and obtain reimbursement.

GRIEVANCE PROCEDURE: If you are not satisfied with the services you receive from the staff assigned to your child or you, or wish to make a complaint please call the Program Manager. If you are not satisfied with the response from the Program Manager, you may submit a written grievance to the Program Director, who will respond to your grievance within 14 days. If you are not satisfied with the response of the Program Director, you may forward your written grievance to the President/CEO. President/CEO will render a decision within 14 days, which will be final. A copy of the full grievance procedure is available upon request.

The information on this page has been explained to me. I understand that I may revoke consent for the above at any time, however, I cannot revoke consent for action that has already been taken. A copy of this release shall be valid as the original.

I have received a copy of the IMPOWER "Notice of Privacy Practices." *This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

I have received a copy of the Outreach Client Guide, which describes my rights and responsibilities, including whom to contact for complaints and grievances.

I certify that I am either the legal custodian (biological or adoptive parent) of the child listed above or I have produced the following legal document naming me as the legal guardian of the child authorized to consent for mental health and/or medical care: Court order signed by a Judge or Notarized statement signed by the parent.

THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED.

______________________________	______________________________
Client Signature	Date
______________________________	______________________________
(If Client is a minor) Legal Guardian Signature	Date
______________________________	______________________________
Witness Signature	Date