INTAKE CONSENTS

Client Name: _____Date of Birth_____

Parent/Legal Guardian Name (if applicable): _____

CONSENT FOR TREATMENT AND TREATMENT LOCATION: I, the undersigned, consent for my child/myself (individual 'Client" named above) to participate in Mental health and Substance Abuse assessment and treatment through IMPOWER. I authorize services consistent with the level of needs per my assessment. I certify that I fully understand the treatment. I have been made aware of the purpose and structure of the program to which I am admitted and the expected length of time in treatment.

I also consent for my *Referral Source*, and 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. _____
2. _____
3. _____

Consent to Receive Telehealth Services

I consent for the individual named above to receiving behavioral health/substance abuse services via telehealth. I will be informed of my diagnoses and proposed telehealth treatment plan. I understand that the individual named above 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 video-conference 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 understand that it is my responsibility to make sure that my child and I are in a confidential, stationary location and properly dressed for our medical appointment. The individual named above and the guardian/caregiver must both attend all appointments. Failure to abide by these requirements will result in cancelation of my/my child's appointment.

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

CONSENT FOR MEDICATIONS: I consent for the individual named above to receive medication treatment including psychotropic medications. I understand a person accepting treatment voluntarily has the right to accept or refuse medication. If I have questions about medication, I may ask the provider.

CONTROLLED SUBSTANCES PROTOCOL: I, the undersigned, acknowledge that if the individual named above is prescribed a controlled substance they will be required to return for follow-up Medication Management appointments at least monthly.

PRIVACY EXCEPTIONS: I, the undersigned, acknowledge that in some circumstances, IMPOWER is 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.

INFORMATION MAY BE SHARED WITH OTHER IMPOWER PROGRAMS.

REPORTING OF COMMUNICABLE DISEASES: In accordance with Florida Statues, I, the undersigned, acknowledge that the Medical Director, or designee, may be required to report any communicable disease that the above named client may have, or be suspected of having, that may pose a significant threat to the general public during the course of treatment.

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 applicable program manager. If you are not satisfied with the response from the program manager, you may submit a written grievance to the applicable 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 Vice President of Quality Management. The VP of Quality will render a decision within 14 days, which will be final. A copy of the full grievance procedure is available upon request.

CONSENT FOR URINALYSIS: I, the undersigned, consent to provide urine samples for analysis whenever requested by IMPOWER. I understand that urinalysis may be used to evaluate my need for treatment and/or monitor my progress in treatment. I understand that visual observation of urine collection by staff may be necessary and, if conducted, will be done by a person of the same gender as the client. I understand that urinalysis results are confidential except as I have given consent for the release of this information or as legally required.

CONSENT FOR SEARCH AND SEIZURE: I, the undersigned, understand that there are times IMPOWER staff may need to conduct searches of my possessions or person in order to maintain the security and safety of the facility.

OUTPATIENT MENTAL HEALTH COUNSELING: I, the undersigned, understand IMPOWER's holistic approach to my treatment. And as such, I acknowledge that recipients of medication management services will also receive mental health counseling. Failure to attend mental health counseling services will result in discharge from the Medication Management clinic.

CONSENT FOR GENE TESTING: If I request genetic testing, and my provider agrees to order the testing, I, the undersigned, understand that by signing this consent, I authorize IMPOWER to submit my/my child's protected health information or related information on my behalf to *GeneSight* and its affiliates.

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 "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 Outpatient Services Client Manual 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.

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