HIP Behavioral Health Consent

Informed Consent for Behavioral Health Services

I voluntarily consent to participate in behavioral health services with Highlands Integrative Pediatrics (HIP). These services may include parent consultation and/or psychotherapy.

General Information

This document provides an overview of the behavioral health treatment process, including the associated risks and benefits. Your signature at the end of this document signifies that you have read and understand the risks and benefits and voluntarily agree to proceed.

The Therapeutic Relationship and the Process of Psychotherapy

The therapeutic relationship is founded on the principles of mutual trust and respect. As a client, you agree to engage in this process with the knowledge that at times it may be emotionally uncomfortable and difficult. HIP behavioral health providers agree to support you through these periods of discomfort as you engage in the process of personal growth.

The success of therapy is largely dependent on your willingness to do the emotional work necessary to address the areas of distress in your life. There are no guarantees in this process however, and no promises that your circumstances will change for the better through therapy. What we at HIP can offer as you engage in this process is empathy, support and clarity about patterns of behavior that may be preventing you from successfully moving forward toward your goals.

Confidentiality

The confidentiality of information you share with your behavioral health provider is protected, with the exception of the following:

1. Threats or actions taken to hurt yourself
2. Threats or actions taken to hurt others
3. Situations which involve abuse or neglect of children
4. Situations which involve abuse or neglect of the elderly or other vulnerable populations
5. Court ordered requests for information

You may request a signed release of information (ROI) from HIP to have your therapy records shared with other individuals or entities.

Because we are an integrated practice, HIP behavioral health providers may communicate with HIP medical providers about your care. This communication between and among providers is confidential and is protected in the same way as your medical and behavioral health records.

By signing below, I attest that I have read this document and have addressed any questions I have about the behavioral health services I am consenting to with my behavioral health provider.

Client name (printed) Date of Birth

Client Signature (minor child may consent and sign for self if over 12 years of age)

Parent/Guardian name (printed)

Parent/Guardian signature for minor child 12 and under

Second Parent/Guardian name (printed)

Second Parent/Guardian signature for minor child 12 and under

Provider Signature

Date: