



A MEMBER OF TRINITY HEALTH

## SAINT JOSEPH MERCY BEHAVIORAL SERVICES CONSENT FOR EVALUATION AND TREATMENT

**Name of Client:** \_\_\_\_\_

**I hereby consent to be evaluated, or to have my minor child evaluated by Saint Joseph Mercy Behavioral Services. I understand that an offer by this facility or attending medical staff to evaluate does not constitute or imply a commitment to treat or otherwise provide services, which may be recommended in the evaluation report.**

**If this evaluation does result in a recommendation for services which are then provided to me by Saint Joseph Mercy Behavioral Services, I agree that my continuing attendance and participation shall represent my consent to being treated by Saint Joseph Mercy Behavioral Services or the attending medical staff.**

**I understand that no records shall be released from the Saint Joseph Mercy Behavioral Services without the express and authorized consent of myself or my legal guardian, or under the conditions specified in the Patient Rights Pamphlet. I have received a copy of the Patient Rights Pamphlet and Patient Information Sheet.**

**I agree to follow the treatment plan set by Saint Joseph Mercy Behavioral Services and its Medical Director. I recognize that Saint Joseph Mercy Behavioral Services may discontinue treatment with me and/or offer other treatment alternatives if I do not comply with the treatment plan.**

**I recognize that I am financially responsible to Saint Joseph Mercy Behavioral Services and/or attending medical staff for charges not paid by insurance. I authorize the release of any medical and/or substance abuse information necessary to process insurance claims. I am aware that I may be charged for a missed appointment if 24 hours notification is not given and that this is not covered by my health insurance.**

\_\_\_\_\_  
**Client's signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent or legal guardian's signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**