LAKE COOK
BEHAVIORAL HEALTH

CONSENT FOR TREATMENT

1. I hereby consent to receive behavioral health services through Lake Cook Behavioral Health as provided by psychologist, social workers and other counseling professionals.

2. I authorize and request that Lake Cook Behavioral Health and my physician(s) perform assessments and administer treatments as may be advisable in the diagnosis and treatment of my condition.

3. I realize that no particular outcome/result can be guaranteed as a result of my consent to treatment at Lake Cook Behavioral Health.

4. I hereby release my psychologist, social worker, counselor, and Lake Cook Behavioral Health and their employees from responsibility for any injury which results from my leaving Lake Cook Behavioral Health services against clinical and medical advice.

5. Your treatment is confidential within the limits prescribed by law. In general, no information about your treatment will be released without your written consent. However, relevant laws require that your therapist contact others about your safety if you present a danger to yourself or others, if your therapist learns of child abuse or neglect, or if ordered by a court.

   In addition, your therapist may consult with other therapists within Lake Cook Behavioral Health to improve the quality of your treatment. Your therapist may release information about you to an insurance company or managed care company if you are using these benefits.

   If you (client) are younger than 12 years of age, your therapist may discuss your treatment with your parents or legal guardian. If you are older than 12 years of age and younger than 18 years of age, your therapist may discuss your treatment with your parent or legal guardian with your consent. If you are engaging in behavior that your therapist believes places you in danger of significantly harming yourself or others, your therapist will help you to discuss these issues with your parents.

6. I agree that I will provide 24-hour notice to cancel a scheduled appointment. If I do not give proper notification, I understand that I am responsible for a fee (insurance cannot be billed for a late cancellation or a missed appointment).

This consent form has been fully explained to me and I certify that I understand and agree with its contents.

Client Name:(printed)____

Client's signature:____Date:___________

Person authorized to consent (Parent or guardian)_________________________________Date:___________

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