SOUTHFIELD MENTAL HEALTH ASSOCIATES, P.C.
17320 W. 12 Mile Road, Suite 101
Southfield, MI 48076

Telephone: (248) 557-4667

I hereby give consent to EAP, evaluation, and/or treatment services for

____myself

____my legal dependent:_____ _____
(relationship)

I understand that a record of my evaluation/treatment will be kept, and if health insurance pays for any portion of fees charged, the record may be reviewed by my insurance company, if requested. Only those items of information that are allowed under federal (HIPPA) regulations will be furnished. I authorize the release of information necessary to process insurance claims, and I authorize payment for services to Southfield Mental Health Associates, P.C. (SMHA) Also, I grant permission for my record to be confidentially reviewed as part of an accreditation survey of SMHA by CARF.

Except as noted above or in the Privacy Notice, or in the event of a medical emergency or court order, my record is strictly confidential and will not be released to anyone without my written consent.

I agree to be responsible for payment for all services received at SMHA, to myself, my spouse, and/or my legal dependent that are not paid by insurance, including deductibles, co-payments, a fee for appointments not kept or canceled less than 24 hours in advance, and any late, collections, and attorney fees (if any) if this account is unpaid.

Upon conclusion of my evaluation/treatment, I understand that SMHA will mail me a brief anonymous questionnaire about my evaluation/treatment experience for the purpose of improving its services. My decision whether to return the questionnaire is completely voluntary. Unless the following statement is checked, I agree to receive the questionnaire: ____ I do not agree to receive SMHA's follow-up questionnaire.

I understand that the services provided by my therapist and SMHA are based on currently accepted mental health practices and that the outcome cannot be guaranteed. I also understand that no representation is made by my therapist or SMHA that they are treating or are responsible for diagnosing any physical medical problem. I agree to consult my physician regarding all physical health matters.

My signature indicates that I have been given a copy of SMHA's Privacy Notice which details the potential uses and disclosures of my record, as well as materials concerning the clinic's Mission, Code of Ethics, Client Rights and Responsibilities, and policy on prevention and control of infectious disease.

_____ _____
Signature Date

_____
Witness