



## INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name of client: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I understand that as a subscriber to any member of the YES Provider Group, i.e., YES Behavioral Health, Youth Residential Services, Life Coach Community Services, Life Changers Mental Health & Supportive Services, and/or The Wellness Center (collectively referred to as "YES"), I am eligible to receive a range of services including medical, psychiatric, psychological, other mental health, social services, and/or educational services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that all information shared with the clinicians at YES is confidential and no information will be released without my consent. During the course of treatment at YES, it may be necessary for my counselor, nurse, therapist or doctor to communicate with other staff from our affiliated provider group. While written authorization will not be requested, prior to any discussion with YES providers, I understand that my counselor, nurse, therapist or doctor will discuss these communications with me. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

- A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
- B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
- C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that a range of medical and/or mental health professionals, some of whom are in training, provides these services. All professionals-in-training are supervised by licensed staff.

I understand that while medical, psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medical treatment and/or medications may have unwanted side effects.

If I have any questions regarding this consent form or about the services offered at any part of the YES Provider Group, I may discuss them with my counselor, nurse, therapist, or doctor. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by any member of the YES Provider Group. I understand that I may stop treatment at any time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### IF CLIENT IS A MINOR

The undersigned do hereby authorize \_\_\_\_\_ or such substitute as he/she may designate as agent for the Undersigned to consent to assessment and/or treatment including emergency treatment (i.e., X-Ray, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon, licensed under the Provision of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date