# FHL Christian Counseling, LLC

##### CONSENT FOR OUTPATIENT TREATMENT

|  |  |
| --- | --- |
| Patient Name (first, middle, last) | Date of Birth |

**1. GENERAL CONSENT TO MEDICAL TREATMENT**

I request & authorize FHL Christian Counseling, LLC to perform medically necessary behavioral health procedures & other services & supplies, as are prescribed for my health & well-being. I acknowledge that no representations, warranties, or guarantees as to results or cures have been made to me by FHL Christian Counseling, LLC nor have I relied upon any such representations, warranties, or guarantees. I understand that attempts will be made to call me prior to my appointments. I authorize FHL Christian Counseling, LLC to call me at the telephone numbers listed on my registration record. I acknowledge that this consent will remain in force and applies to subsequent outpatient treatment unless revoked by me.

**2. RELEASE OF INFORMATION**

I authorize FHL Christian Counseling, LLC to release a copy of my medical records to my insurance carrier or third party payers, or in connection with Worker’s Compensation, to others responsible for insurance claims & investigations. I also authorize FHL Christian Counseling, LLC to release any information needed for this or any related Medicare/Medicaid claim to the Social Security Administration or its intermediaries or carriers. I further authorize the release of my medical records to any individual or organization engaged by FHL Christian Counseling, LLC to disclose information concerning my medical condition to any other provider directly involved in my medical treatment (i.e. PCP). I hereby release FHL Christian Counseling, LLC from all legal liability that may arise from the disclosure of such information.

**3. CONSENT FOR MENTAL HEALTH SERVICES**

I, the undersigned, agree & consent to participate in the mental health services offered & provided by FHL Christian Counseling, LLC, who employs mental health providers, as defined in Indiana law. I understand that I am consenting & agreeing only to those mental health services the providers are qualified to provide within: a) the scope of the provider’s license, certification, & training; or b) the scope of license, certification, & training of those mental health providers directly supervising the services received by the patient. I agree to pay all accumulated charges not covered by verified & assigned insurance.

All information is kept confidential except when reporting is required by State Law, including if you are: 1) homicidal; 2) suicidal; 3) under 18 & being sexually or physically abused; 4) under 16 & sexual partner is 18 or older; 5) under 14 regardless of age of sexual partner; 6) if requested by legal authorities or subpoena.

|  |  |
| --- | --- |
| Patient’s Signature | Date |

|  |  |
| --- | --- |
| Witness/Consent for minor or incompetent adult | Date |