LIFESOURCE
Healthcare Management Services

Request for Mental Health Services: Consent to Treat

Patient Name: _____ **Patient DOB:** _____

Patient Location: _____ **Service(s) Requested:** ☐ **Mental Health**

I request the above services from the LifeSource of NC, Inc. clinician designee(s). I understand that this may include psychiatry and/ or psychotherapy treatment for emotional, behavioral, or cognitive problems, and/or psychotropic medication management. I understand that LifeSource Healthcare Practitioners are responsible for discussing with me the nature of my care, the treatment I will receive, information concerning benefits of the treatment proposed for me, the way it is to be administered, expected side effects or risks of treatment and medications, alternative treatments, and the probable consequences of no treatment. I also understand that I have the right to participate in the development and implementation of my treatment plan of care with LifeSource Practitioners.

I have been informed of my rights, including the right to consent to or refuse treatment; I have received or been offered a copy of LifeSource's Client Rights', Responsibilities, and Grievance policies, as well as the Notice of Privacy Practices, which provides information about how LifeSource uses and discloses Protected Health Information.

I understand that the healthcare Practitioners providing services to me may be independent providers who are not employees of the Facility. I understand that it is the responsibility of Facility personnel to carry out such Healthcare Practitioners' instructions, but that Facility is not liable for any act or omission when following the instructions of such Health Care Practitioners. I have been advised that all or some of the services provided to me may be delivered via telehealth. I have received a copy of LifeSource's Telehealth Policy, had the form explained to me, understand its contents (including the risks and benefits of telehealth services) and have had ample opportunity to address any questions or concerns I had regarding this service delivery method.

I understand that this organization is obligated by the State of Wisconsin to report any suspicion of abuse and/or neglect. I am aware that the practice of medicine and psychology is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations, treatments or services provided to me by LifeSource practitioners.

I authorize any entity with medical information about me to release said information to my insurance company or to the Centers for Medicare and Medicaid Services and its agents, if needed, to determine the benefits payable for requested services.

I request that payment of authorized insurance benefits be made on my behalf to the LifeSource clinician designee for requested services. I understand that my insurance company may assign a portion of the bill as patient liability. I understand that my financially responsible party may be informed that I am receiving services for billing purposes unless I request otherwise.

I authorize the release of information to my Attending Physician and/or facility for the purpose of coordination of care. I understand that my medical records will be kept on file at the site where requested services are provided, and that the release/ disclosure of my protected health information is subject to all HIPAA guidelines.

The duration of this consent is until the discontinuation of service by the provider or patient.

REQUIRED SIGNATURES: ***(If signing as Legal Guardian, proof of guardianship required)***

_____	_____	_____
Patient or Legal Guardian Signature	Patient or Legal Guardian Printed Name	Date
_____	_____	_____
Witness Signature *(If signature illegible)*	Witness Printed Name	Date

Or, in accordance with Medical Statutes:

_____	_____	_____	_____
Responsible Party Signature	Responsible Party Printed Name	Date	*Relationship to Patient (Required)*