MISSION BEHAVIORAL HEALTH

Fax: (256) 427-4165

Missionbehavioralhealth@gmail.com

Informed consent for Mission Behavioral Health

I do hereby give consent to Mission Behavioral Health (MBH) for evaluation and treatment if indicated. The evaluation and treatment may include, psychotropic medication recommendations, physiological assessments and therapy.

It is understood that MBH is a private company that is not affiliated with or have joint ventures with my residing facility. I understand that MBH is my mental health provider and will consult with facility staff, medical providers and will have access to my medical charts to propose treatment. I also give MBH permission to receive/take my photographic image for proper identification.

I understand that all payments for services provided by MBH will be billed to insurance provider(s). I understand that I am responsible for all reimbursement to MBH that insurance provider(s) do fully cover. I also request that payment of authorized Medicare benefits or third payor sources be made on my behalf to MBH. I authorize the release of any medical information necessary to process claims to insurance provider for payment.

Patient's Rights of treatment with Mission Behavioral Health

- Be treated with respect and dignity
- Have their privacy protected
- Receive services appropriate for their age and culture
- Understand treatment options and alternatives
- Get care that doesn't discriminate on the basis of age, gender, race, or type of illness

I have been provided an informed consent and patient rights of treatment with MBH. I have also been given a copy of the HIPPA Notice of Privacy Practice.

_____ _____

Patient Signature

Guardian/POA Signature/Date and Time

_____ _____

Patient name

Verbal Consent/Witness/Date and Time