INFORMED CONSENT FOR MENTAL HEALTH TREATMENT

As a client of *Inspire Behavioral Health*, I have access to participate in a variety of treatments to address my mental health concerns. The type and extent of treatment services that I will receive will be determined following an initial intake and treatment planning session with a trained clinician. The goal of this process is to determine the best course of treatment for me based on my diagnosis and personal treatment preferences and goals.

I understand that all information shared with the clinicians at *Inspire Behavioral Health* is confidential. That is, information will not be shared outside of the agency except in the circumstances itemized below. If information is needed by non-agency providers or other individuals involved in my care, I understand that I need to provide written consent for Inspire providers to release this information to identified parties. 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:

1. When there is risk of danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
2. When there is suspicion that a child or vulnerable adult is being abused or is at risk of abuse, the clinician is legally required to take steps to protect the child or vulnerable adult, and to inform the proper authorities.
3. When a valid court order is issued for medical records, the clinician and the agency may be bound by law to comply with such requests.

I understand that the clinicians at *Inspire Behavioral Health* utilize treatments with strong evidence showing that they are effective for treating substance use and other mental health conditions. However, if I believe that I am not benefitting from treatment, I have the option to discuss alternative treatment options with my provider. I also understand that while treatment may provide significant benefits, it may also pose risks. The work we do in sessions may elicit uncomfortable thoughts and feelings, and making behavioral change may impact my relationships. My providers are available to answer any questions that I may have regarding these benefits and risks.

If I have any questions regarding this consent form or about the services offered at *Inspire Behavioral Health*, I may discuss them with my treatment provider. I understand that I may refuse or discontinue treatment at any time, though it is recommended that I speak with my treatment provider before doing so in order to discuss alternative treatment options. By utilizing treatment services at *Inspire Behavioral Health*, I acknowledge my understanding and agreement with the above outlined policies and I consent to participate in the evaluation and treatment offered to me.

Client Name (Printed): _____ DOB: _____/_____/_____

Client Signature: _____ Date: _____/_____/_____