500 W. Central Rd.
Suite 200
Mount Prospect, IL, 60056

Informed Consent for Mental Health Services

NAME: _____ **DOB:** _____

I hereby give my consent to participate in mental health services offered by Ramos & Associates Behavioral Health Clinic ("the Clinic"). I understand that this consent is voluntary, and that I can change my mind and not participate at some future time. I have discussed with Clinic representatives the risks and costs involved in the mental health treatment, including the nature of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment.

As a client of Ramos & Associates Behavioral Health Clinic, I recognize my responsibilities to:

- Participate in the treatment program and therapeutic activities specified in the treatment plan recommended for me by clinic staff.
- Not engage in assaultive or destructive behavior toward clinic staff, other clients, visitors, or property. I understand that such behaviors may constitute grounds for discontinuing service.

I have read and /or had read to me and been given a copy of a statement of my rights, including the Client Grievance Procedure. I have been given a copy of the Clinic's Notice of Privacy Practices, which explains how the Clinic will use and disclose my health information.

THIS CONSENT IS VALID UNTIL: _____

Client: I have read the above and attached statements or have had them read and explained to me in a language in which I understand.

_____	_____	_____
Signature of Client	Printed Name of Client	Date
_____	_____	_____
Signature of Parent or Guardian (if Client is under 18)	Printed Name of Parent or Guardian	Date

Clinic Representative: I have explained the above and referenced documents to the client to the best of my ability. The client understood this consent form to the best of my knowledge.

_____	_____	_____
Signature of Clinic Representative	Printed Name of Clinic Representative	Date