Pediatric Behavioral Health Institute
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INFORMED CONSENT FOR ASSESSMENT, TREATMENT AND DISCHARGE

Client Name: _____ D.O.B. _____

The above name individual has been referred for services through the SEAL Therapeutic Corporation DBA The Pediatric Behavioral Health Institute. Before treatment is provided, we must conduct an assessment to determine eligibility and plan for treatment, which best meets the needs of the client.

A qualified clinician will conduct the assessment. Evaluations tools will be carefully selected based on clients' needs. Information about client and/or family member may be requested I order to provide needed treatment services and support. Treatment may include psychotherapy or psychotherapy techniques which are aimed at helping clients process and rectify situations that are troublesome in my life. Psychotherapy can at times cause a temporary sadness or agitation dependent upon the topic being discussed.

I understand that my clinician is obligated by law to report incidents of suspected child abuse/neglect to the Department of Children and Families. I understand that if I disclose that someone is hurting me, my clinician may be obligated by law to tell a helping authority. I understand if I disclose that I want to hurt myself, my clinician is obligated by law to tell a helping authority or begin Baker Act procedures that will cause involuntary hospitalization.

If I am unhappy with my treatment within this agency I understand that there is a grievance procedure. I understand that if I am unhappy with the clinical treatment that I am receiving that I can discuss this with my clinician, the clinical director or with the executive administrative assistant. I am also able to stop treatment with this agency whenever I would like.

I understand that my clinical information may be shared with my clinician's supervisor or with other SEAL /PBHI clinicians for the purposes of enhancing my clinical care. I hereby give my permission to bill my health care insurance carrier, Medicaid, or other designated health benefits payor. I understand it may be necessary to release certain clinical information to my insurance company in order to secure such payment.

I understand that I will automatically be discharged from treatment after thirty days of no contact with my therapist. I also understand that, in most circumstances, with the clinical director or designee's approval, I am able to restart treatment again if I feel the need to, despite the reason for discharge.

By signing this form, I _____, voluntarily grant permission for the SEAL Therapeutic Corporation to conduct and assessment and subsequent treatment. I acknowledge that my rights have been explained; the limits of confidentiality and the grievance policy have also been explained.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Witness Signature Date