Alliance Behavioral Health Integrated

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General Consent for Treatment, Services & Telehealth

I voluntarily consent to receive healthcare services from Alliance Behavioral Health Integrated. Services may include primary care, preventive care, medical evaluation, laboratory orders, medication management, behavioral health services, psychiatric evaluation, psychotherapy, care coordination, referrals, telehealth services, and other services recommended by my provider.

I understand that healthcare is not an exact science and no guarantee has been made regarding treatment outcomes.

Informed Consent

I understand that informed consent is an ongoing communication process between me and my provider. I have the right to ask questions and receive information about recommended treatment, expected benefits, reasonably foreseeable risks or side effects, alternatives, and my right to refuse or withdraw consent except where required by law or in emergencies.

Telehealth Consent, If Applicable

I understand that some services may be provided through telehealth when clinically appropriate. I understand telehealth may involve audio, video, electronic communication, or remote monitoring tools. Benefits may include improved access to care, and limitations may include technology failure, privacy risks, or the need for in-person care. I may withdraw telehealth consent at any time.

Use and Disclosure of Health Information

I understand that ABHI may use and disclose my health information for treatment, payment, and healthcare operations as permitted by HIPAA and other applicable laws. This may include communication with providers involved in my care, laboratories, pharmacies, referral sources, and insurance plans as needed for care coordination and billing.

Confidentiality and Safety Exceptions

I understand that my health information is confidential and protected by state and federal law. Exceptions may include emergencies, risk of serious harm to myself or others, suspected abuse or neglect of a child, elder, or vulnerable adult, court orders, legal requirements, audits, treatment, payment, healthcare operations, and other disclosures permitted or required by law.

Patient Responsibilities

I agree to provide accurate information, participate in treatment planning, follow clinic policies, ask questions when I do not understand, keep scheduled appointments or provide timely notice of cancellation, and provide current insurance and billing information.

By signing below, I acknowledge that I have read and understand this consent, have had the opportunity to ask questions, and voluntarily agree to receive services from ABHI.

Patient / Legal Guardian Signature _____

Date _____

Relationship to Patient, if applicable _____

Printed Name _____

Staff / Witness Signature _____

Date _____