AI Initial Consent for Treatment
General Consent for Evaluation and Treatment

TO THE CLIENT: Welcome! At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluations necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended diagnostic procedure to be used. You may then decide whether to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides us with your permission to perform reasonable and necessary evaluations and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

You have the right to discuss the treatment plan with your counselor about the purpose, potential risks and benefits of any procedure recommended for you. If you have any concerns regarding any assessment tool or treatment recommended, we encourage you to ask questions.

I voluntarily request a counselor/therapist, or the designees as deemed necessary, to perform reasonable and necessary evaluations, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified. I understand that if additional testing, treatments, or interventions are recommended, I will be asked to read and sign additional consent forms prior to the treatments(s) or procedure(s).

Financial Responsibility

I accept that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me.

I acknowledge that not all services provided by **Alternative Interventions, Inc** are covered by my insurance plan for one or more reasons, including but not limited to exclusions from my insurance plan, my insurance plan's designation of the Health Center as an out-of-network provider, and/or my failure to provide my insurance card.

Authorization (PLEASE COMPLETE):

I authorize payment directly to **Alternative Interventions, Inc** for services for which the Center accepts payment. I accept responsibility for all charges if I do not have medical insurance. I have been informed that the services provided may not be covered by my insurance plan. I elect to proceed with service with the understanding that I may be personally responsible to pay for the service being rendered to me.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

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Signature of Client or Representative Date

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Printed Name of Client or Representative Date