

Lily Health and Wellness Center

Location: Annapolis, MD 21401

Phone: 240-425-4487

Fax: 240-425-4255

Email: admin@lilyhealthmd.com

Consent to Mental Health Services

This form documents your voluntary consent to receive mental health services from **Lily Health and Wellness Center Telepsychiatry**. Please read this document carefully before signing.

Consent and Acknowledgment

By signing this form, I acknowledge and agree to the following:

- I voluntarily consent to mental health services being provided to me, or to the individual for whom I am the legal representative or legal guardian (including Power of Attorney).
- The nature, purpose, risks, and potential benefits of mental health treatment have been explained to me.
- Alternative treatment options, as well as the option of no treatment, have been discussed.
- I understand that there is **no guarantee** that any specific result or outcome will be achieved through mental health services.

Do not sign this form if you have unanswered questions that are important to your decision to consent.

Scope of Services

I understand and agree that the mental health services provided will be within:

- The scope of the treating provider's license, certification, education, and professional training; and/or
 - The scope of the license, certification, education, and training of supervising mental health professionals, when applicable.
-

Client Handbook Acknowledgment

I, **Client Name:** _____, acknowledge that:

- The **Client Rights and Grievance Procedures** have been explained to me.
- I have received a copy of these rights and procedures.
- I have been provided a copy of the **HIPAA Notice of Privacy Practices** and understand how my protected health information may be used, disclosed, accessed, and controlled.

If the client does not sign this acknowledgment, Lily Health and Wellness Center Telepsychiatry will document good-faith efforts made to obtain consent or the reason consent was not obtained.

Authorization for Use and Disclosure of Health Information

By signing this form, I authorize Lily Health and Wellness Center Telepsychiatry to use and disclose my protected health information as necessary to:

- Provide, coordinate, and manage my mental health care;
- Seek and receive payment for services rendered; and
- Conduct healthcare operations in accordance with applicable federal and state laws.

Signatures

Client / Patient Signature: _____

Date: ____

Parent / Legal Guardian / Power of Attorney (if applicable)

Name: _____

Relationship to Client: _____

Signature: _____

Date: ____

Lily Health and Wellness Center Clinical Staff Signature: _____

Date: ____