Elliot Behavioral Health Services
Tel: (603) 668-4079 Fax: (603) 663-8605

INFORMED CONSENT FOR BEHAVIORAL HEALTH SERVICES

Patient Name: DOB:

I request, consent and authorize the Elliot Health System, and its affiliates, including, SolutionHealth, Elliot Physicians Network and Elliot Professional Services (hereinafter referred to as the "Elliot) to provide care and treatment as determined necessary or advisable.

I understand and agree with the various aspects of this informed consent. My clinician will review my treatment plan with me, which includes my evaluation, diagnosis and the method of treatment. The nature of the treatment will be explained to me, including possible side effects and alternative forms of treatment, and the related risks and benefits. I understand that I may withdraw from treatment at any time; but if I decide to do this, I will discuss my plan with my clinician.

I understand and acknowledge the information I disclose to my clinician will be kept confidential within the limits of state and federal law. Communications between mental health clinicians and clients are typically confidential, although there are circumstances in which clinicians are permitted or required to disclose certain information under state or federal law. Examples of such exceptions include but are not limited to:

a. abuse of a child;
b. abuse of an incapacitated adult;
c. compliance with Health Information Portability and Accountability Act (HIPAA) or other disclosures permitted by HIPAA (**see Elliot's Notice of Privacy Practices for more information**);
d. certain rights you may have waived to obtain health insurance coverage for these services;
e. court orders or subpoenas; or,
f. serious threat to property, self or others.

The Elliot is a member of SolutionHealth and as such maintains one electronic medical record for each patient allowing SolutionHealth treating providers to access their patient's complete medical record for purposes of continuity of care, evaluation and treatment planning. SolutionHealth is also comprised of Southern New Hampshire Health System (SNHHS). This means SolutionHealth, Elliot and SNHHS providers have access to evaluations, diagnoses, medications, test results, operative reports, office visit notes, x-rays, hospital discharge summaries and other medical information relating to your care at The Elliot.

I understand that I have the right to request restrictions on the health information my clinician uses or discloses about me for treatment, payment or health care operations. However, my clinician is not required to agree to the restrictions requested. I understand that if my clinician agrees to a requested restriction, the Elliot Behavioral Health Services staff will honor that restriction. However, I understand that if I request certain medical information not be disclosed to my insurance carrier and that information relates to health care services for which the Elliot has received payment in full from me or on my behalf (from a third party other than my insurance company), then my clinician must agree to that request.

Revoking Consent

I understand that I may revoke this consent in writing, except to the extent that Elliot and SolutionHealth have already taken action in reliance thereon. I further understand that if I revoke my consent to receive services, then I can no longer receive services from my clinician until I execute a new informed consent.

Missed Appointments

I understand that I will be subject to a missed appointment fee if I do not keep a scheduled appointment or cancel the appointment with less than 24 hours of notice. I understand that if I am 10 minutes late for my scheduled appointment, I will need to reschedule the appointment, and that my late arrival will be considered a no show.

Scope of Practice

I understand that my Elliot Behavioral Health Provider operates under a scope of practice for which they have been trained. To the best of their ability, the provider will inform me of their scope of practice, at any point in time, if a clinical issues arises which is outside the providers scope of practice they will do their best to connect me to a provider, within SolutionHealth, Elliot Behavioral Health or a community provider who is best trained to treat the presenting issue.

I confirm that I have read and fully understand this consent. I agree that I have been given the opportunity to ask questions and all my questions have been answered to my full satisfaction. I give permission for myself or child to receive services from Elliot Behavioral Health Services.

Patient or Authorized Representative Signature

If Authorized Representative, please print name and check applicable relationship:

Name: _____ Date _____

___ Parent
___ Guardian with Parental Rights
___ Court Appointed Guardian
___ Health Care Power of Attorney
___ NH DHHS