CONGENIAL HEALTHCARE, LLC

PATIENT INFORMED CONSENT to Collaborative Care Model (CoCM)

I consent to receive collaborative care services through Congenial Healthcare, LLC. I understand that this means the behavioral health manager, my primary care physician, and (if applicable) my psychiatrist will communicate about my plan of treatment.

I acknowledge that I am here voluntarily and that I may terminate my treatment at any time. I agree to actively participate in my treatment plan, therapeutic goal setting, and sessions with my behavioral health care manager. I further acknowledge that the counseling session is only one part in the process of change and that following through with activities and new behaviors will be a key part of the therapeutic process.

I agree to, if possible, call 24 hours ahead of my appointment if I need to cancel. If a last-minute cancellation is necessary, I agree to notify the front desk prior to the start of my appointment. I understand that if I show up 10 minutes late to a 30-minute appointment or 15 minutes late to a 60-minute appointment that my appointment will be canceled and that I will need to reschedule.

I understand that to remain enrolled in the CoCM program I will need to meet with my behavioral healthcare manager a minimum of 1 time every 6 weeks. If I fail to meet these requirements, I understand that I will be unenrolled from CoCM. If I desire to re-enroll I understand that I can ask my PCP at any time and I will restart the enrollment process.

I understand that information about my treatment and communications with my behavioral healthcare manager may not be released without my written authorization. This is with the exception of extremely rare situations in which a court orders the records to be released. For a comprehensive list as well as a complete review of my rights, I may request a copy of the Congenial Notice of Privacy Practices from my provider.

I have had the opportunity to discuss this informed consent statement with my behavioral healthcare manager. I understand its meaning and consent to receiving services based on this understanding.

I understand that my behavioral healthcare manager will not discuss my treatment with anyone other than those on my treatment team. I also understand that my behavioral healthcare manager is a mandated reporter, and that confidentiality does not extend to reports that I am a threat to myself or others and in cases of child or elder abuse and neglect.

I understand that cost sharing applies for these services, and I agree to be responsible for any co-payments. Billing dates may vary depending on individual insurance plans. Dates of billing may not reflect dates of patient service due to psychiatric review necessary for enrollment in CoCM program. If you have any questions about coverage or cost contact your insurance company.

Date: _____

Print Name: _____

Client Signature: _____

DOB: _____

Therapist Signature: _____