C. Saks Behavior Therapy Services

(505) 690-7372 • FAX (505) 629-1580
Email: csaksbehaviortherapy@hotmail.com
P.O. Box 5787 • Santa Fe, New Mexico 87502
www.csaksbehaviortherapy.com

CONSENT FORM

I authorize and request C. Saks Behavior Therapy Services to provide a range of behavioral therapy services. I realize my insurance or medicaid funding source may limit eligibility:

- Positive behavioral support, assessment/plan
- Screening for depression, anxiety or other mood and mental health issues
- Assessment of developmental functioning in different life areas
- Crisis Prevention/Intervention
- Family Support
- Home/Site Visits
- Caregiver/Provider Education and Training
- Therapy Sessions
- Interdisciplinary Team Collaboration/Consults

I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that the therapy process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my therapist and me. _____initial

I understand that my therapist is obligated to report incidents of abuse, neglect, death, risk of harm to self or others and other serious incidents outlined under the incident reporting orientation packet that I can view online (www.csaksbehaviortherapy.com) or receive in hard copy.
_____initial

I also understand that as a condition to my receiving treatment from C. Saks Behavior Therapy Services, C. Saks Behavior Therapy Services may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of this agency. These uses and disclosures are more fully explained in the Privacy Notice which I can view online (www.csaksbehaviortherapy.com) or receive in hard copy. I understand that the privacy practices described in the Privacy Notice may change over time.
____initial

I understand that my confidential information may be disclosed within this agency for purposes of administrative supervision and clinical consultation. Confidential information may also be disclosed outside of this organization for consultation with DDSD/Office of Behavioral Services (for DDW and State General Fund services) and for external clinical supervision to assure best practices. Information will only be disclosed only to the extent necessary to assure quality of care _____initial

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that C. Saks Behavior Therapy Services has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent. _____initial

_____	_____	_____
Signature (client)	Print Name	Date
_____	_____	_____
Signature (legal guardian)	Print Name	Date