Ability Health & Rehabilitation, LLC.
4696 W. Overland Rd. #224, Boise Idaho 83705
Phone: 208-333-9578
Fax: 208-333-9582

Consent to Treatment by Provider

I hereby consent to take part in treatment through the undersigned Provider. I understand that developing a treatment plan with this provider and regularly reviewing progress towards treatment goals are in my best interest, I agree to play an active role in this process.

I understand that no promises have been made to me regarding the results of the proposed treatment. I agree and acknowledge that participation in treatment involves both risks and benefits and that the risks and benefits have been explained to me. The risks and benefits include, but are not limited to, the following:

Benefits

- Determining my strengths and goals for treatment,
- Choosing which goals are priorities and working with my provider in deciding how to reach those goals,
- Having the opportunity to become more independent,
- Enjoying increased satisfaction with the quality of my life,
- Developing a personalized plan to address safety of crisis situations,
- Experiencing an increase in positive responses to difficult situations,
- Improving my coping abilities and reducing my stress,
- Improving my personal relationships.

Risks

- Experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness and helplessness,
- Being in touch with painful emotions, sometimes for the first time, which may temporarily lead to feeling worse,
- Recalling or talking about unpleasant aspects of your life, which can bring up uncomfortable feelings,
- Personal growth sometimes requires changes that may be uncomfortable or unexpected,
- Significant others may notice the changes I make, my relationships may be effected,
- There are no guarantees of what I will experience.

Acknowledgement of Rights

- I understand that I have a choice of provider agency and that I have the right to and did in fact participate in and make decisions regarding the type and amount of services required.
- I further acknowledge and am informed of the availability of service coordination, the purpose of service coordination, my right to refuse service coordination and the right to choose my service coordinator and other service providers.
- I am aware that I may stop treatment with the undersigned Provider and that A Better Life Behavioral Health Services, Inc at any time and that I can request a referral to another provider or to request a second opinion.
- I have been advised that I have the right to file a complaint with the undersigned provider's licensing agency without retaliation and I have the right to refuse treatment.

Acknowledgement of Obligation

- If I choose to stop treatment with the undersigned provider, I agree that I will be responsible for is paying for the services I have already received, if not covered by insurance. I understand that I may lose other services or may have to deal with other problems if I stop treatment.
- I further understand and agree that I must call to cancel an appointment at least 24 hours before the appointment. If I do not cancel or do not show up, I may be charged for the appointment. If my insurance does not cover services and I don't make arrangements for payment my services, the undersigned provider is under no obligation to continue to provide services.

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Acknowledgement of Receipt of Information
I agree and acknowledge that I have received disclosure of the following:

- I have been advised of the name, business address and phone number of the Provider
- I have been advised that if the undersigned Provider is practicing under supervision, I have been advised of this fact and I have been advised that the designated supervisor's name, business address and phone number.
- I have been advised of the license type and license number, credentials and certifications of the undersigned Provider.
- I have been advised of the formal education and the name of the institutions attended and the specific degrees received by the undersigned Provider.
- I have been advised of the theoretical orientation and approach of counseling (e.g., counseling, marriage or family therapy).

Inappropriate Relationships
I agree and acknowledge that sexual intimacy with mental health provider and a participant is never appropriate, and any such circumstance is to be reported to the provider's licensing agency. The name, address and telephone number of the undersigned provider's licensing board is as follows:

Reporting Obligations / Limitation of Confidentiality
I understand that the undersigned Provider and Ability Health and Rehabilitation, LLC and its employees and subcontractors are required by law to report cases of abuse, abandonment or neglect of a child and abuse, neglect or exploitation of a vulnerable adult. See Idaho Code §16-1605 and 39-5303.

I have read and agree to the terms set forth in the Agency Disclosure Form attached hereto.

**By signing below you state that you have read, understood and agree with confirming your consent for treatment.

_____ _____
Participant Signature Date

_____ _____
Provider Date

_____
License Number

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Agency Disclosure Form

I understand and agree that the services provided by A Better Life Behavioral Health Services, Inc, including, but not limited to, pharmacological management and psychotherapy services, may be performed by independent contractors, not employees, selected by A Better Life Behavioral Health Services, Inc.

I further acknowledge and agree that A Better Life Behavioral Health Services, Inc is not responsible for the provision of services by an independent contractor. I herby release and agree to hold harmless A Better Life Behavioral Health Services, Inc from any and all liability, claim or action of any nature whatsoever arising out of the facts or omissions of said independent contractors.

_____

Participant Signature