700 Washington Blvd Baltimore, MD 21230
(410) 779-3102 Office ▪ (410) 230-2687 Fax ▪ www.UBAwellness.org

Treatment Consent Form

Please initial each box to the left as you read each section

Initial	
☐	I request that Urban Behavioral Associates, P.A. (UBA) and its qualified staff provide medically necessary and appropriate Mental Health services deemed medically
☐	In agreeing to receive services from UBA, I understand that I will assist by following the Individual Treatment Plan that has been developed or will be developed for me.
☐	I have received a copy of the UBA Patient Handbook.
☐	I understand that UBA will create and maintain records of my social and health history, symptoms, diagnosis, test results, treatment and plans for future care and treatment. I understand that my record is used as a basis for planning my treatment and care, source of billing information, means of sharing information among the professional staff of UBA, and as a tool to assess quality and review competence of health professionals.
☐	I have been informed of my Heath Information Rights. I understand that I have the right to refuse the use of my health care information for any reason other than treatment, payment, or health care operations. I understand that I have the right to inspect, copy, and amend my personal health information except psychotherapy notes. I understand that I have the right to request restrictions on how my social and health information is used or disclosed for the above purposes, but that UBA is not required to agree to the restrictions I request. And I also understand that I have the right to revoke this consent in writing unless an action has already been taken.
☐	I request the following restrictions on the use or sharing of my health information:

_____

_____

☐	
☐	I have received a copy of the **Grievance Procedure** from UBA. I acknowledge that I understand the grievance procedure.
☐	I have received a copy of the **Discharge Procedures** from UBA. I acknowledge that I understand the discharge procedures.
☐	I have received a copy of the **Crisis Plan** from UBA. I acknowledge that I understand the Crisis Plan.
☐	I consent for UBA to contact me regarding appointments, compliance audits, customer service and in-house marketing.

_____ _____
Patient Signature Date

_____
Patient Name (please print)

_____ _____
Parent/Guardian (if applicable) Date