Alliance Behavioral Medicine, LLC
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Anchorage, AK 99508
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CONSENT FOR TREATMENT

In order to provide effective treatment, a number of considerations must be agreed upon before beginning. Please read and sign below. If you have any questions, please ask.

I, ______________________________________, request and agree to receive behavioral health services from Alliance Behavioral Medicine, LLC. I voluntarily consent to such care and services as deemed medically necessary by mental health professionals with the understanding that I have the right to be fully informed regarding diagnosis and treatment options and to be fully involved in my treatment plan.

I understand that I have the right for my personal information to be kept private. I understand that my rights to privacy are limited by State and Federal law; and only in an emergency or if required by law records will be released without my consent. These circumstances include but are not limited to: known or suspected abuse or neglect of a minor or a vulnerable adult; threat of suicide or harm to another person; compliance with court orders and subpoenas; and other emergency situations.

I understand that my active engagement is a necessary ingredient for treatment success. I agree to attend all of my scheduled appointments and to cancel as quickly as possible if circumstances arise that keep me from attending my appointment. I understand that I will be charged for appointments cancelled or rescheduled with less than sufficient notice and that a pattern of missed or canceled appointments jeopardizes my continuing treatment at Alliance Behavioral Medicine, LLC.

Signature _____________________________________ **Date** __________________

HIPPA ACKNOWLDEGEMENT

NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge I was offered a copy of the Alliance Behavioral Medicine's Notice of Privacy Practices.

Signature of Acknowledgement _______________________________ **Date** ___________