SENIOR MENTAL HEALTH SOLUTIONS, LP

Consent for Services

Patient Name _____ Facility _____

A recommendation and referral for services has been made to Senior Mental Health Solutions, LP for specialized care of your mental health. A qualified Licensed Clinical Social Worker - Advanced Clinical Practitioner will provide these services. The fees for this service will be billed by Senior Mental Health Solutions, LP according to your insurance carriers, i.e. Medicare, Medicaid and secondary plans. You will be responsible for the co-pay where applicable.

With this understanding, I _____ give consent for services and request that payment under my medical insurance is made to Senior Mental Health Solutions, LP for these services. I hereby give permission to Senior Mental Health Solutions, LP to contact my family or responsible party regarding this consent form and discussion of treatment rendered. Patient Social Security # _____

_____ _____

Patient signature Date

_____ _____

Responsible party signature Date

(If patient is unable to consent on their own behalf)