Neurobehavioral Consultants

Consent for Services

I am requesting mental health services/evaluations for myself and/or my family members.

Person(s) to receive services/evaluations:

_____

Please list all family members who will be participating in receiving mental health services/evaluations

I understand that services may include psychiatric or psychological assessments, individual, group, or family psychotherapy, psychoeducational services, and/or consultation.

I understand that all forms of mental health treatment and assessment in which I participate are to be performed at my own risk and without liability to the independently licensed service provider, Jeffrey R. Brusini, LMHC, or Neurobehavioral Consultants, LLC or its contracted service providers.

I understand that all information shared with my service provider will remain confidential in accordance with federal and state regulations. I understand that any information about my treatment will not be released without my written authorization, unless as otherwise specifically provided by law. I understand that records of my treatment are subject to review by my third party payer.

Appointment times will be arranged for the mutual convenience of the patient and the service provider. If I am unable to keep a scheduled appointment, I agree to call and cancel within twenty-four (24) hours in advance of the appointment. I understand that I am responsible to pay for appointments that I do not cancel within twenty-four (24) hours. Fees must be paid at the time of service. There is a fee of $25 for any checks returned to NCSS for lack of sufficient funds. Any alterations to this agreement must be made in writing and signed by the patient and Jeffrey R. Brusini, LMHC.

I understand *completely* that NCSS, LLC will not administer evaluative or diagnostic services or engage in any type of treatment for issues that may involve disputes regarding legal or physical custody of a minor child, divorce proceedings, forensic evaluations, or any litigation in any form, whether civil, criminal, or family court proceedings.

I will retain a copy of this signed agreement for my records. By signing this instrument, I acknowledge all obligations contained herein.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
If patient is a minor

Witness Signature: _____ Date: _____

23 North Road, Peace Dale RI 02879
2893 Post Road, Warwick RI 02886
(401) 831-NCSS www.ncssri.com