Alpine Clinic, LLC
Consent for Mental Health Services/Substance Abuse

I, the undersigned, agree and consent to participate in the mental health services/substance abuse offered and provided by _____, a mental health/substance abuse provider, psychologist, or psychiatrist, as defined in Indiana Law. I understand that I am consenting and agreeing only to those mental health services the above named provider is qualified to provide within: (a) the scope of the provider's license, certification and training; or (b) the scope of license, certification, and training of those mental health/substance abuse providers directly supervising the services received by the patient.

I understand that the treatment offered will be best suited to the problem presented by me or my family. This treatment will consist of an interview to assess the nature of the problem and counseling or psychotherapy to help solve the personal aspects of the problem. In some instances, medication may be recommended and/or prescribed by Alpine Clinic, LLC psychiatrist to help control the medical aspects of the problem.

I understand and agree to the above conditions for treatment to be received.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

This consent must be signed by the patient or by the legal guardian if the patient is a minor or is physically or mentally incompetent. If the patient's signature is not present above, please complete the following:

_____ _____
Parent/Guardian Print Name Reason Patient is Unable to Sign

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date