Northeast Ohio Behavioral Health, Ltd.

PERMISSION FOR TREATMENT

I hereby authorize Northeast Ohio Behavioral Health, Ltd. to provide ___________________________
Client's Name

with the following services:

__________ Individual Psychotherapy
__________ Psychological Testing/Evaluation/Assessment
__________ Family Counseling
__________ Custody Evaluation
__________ Parent Consultation
__________ CPST – Community Psychiatric Supportive Treatment
__________ Other ____

I understand that mental health services sometimes carry a risk of undesirable side effects and am aware that I am entitled to an explanation of such possible side effects. I further understand that only those services listed above will be provided unless I give signed authorization for additional services.

____
Signature of Client or Parent/Legal Guardian

____
Relationship to Client (if under 18)

____
Signature of Witness

____
Date

Client Rights, Civil Rights and Grievance Procedures:

I have received a copy of Northeast Ohio Behavioral Health, Ltd.'s Client Rights, Civil Rights and Grievance Procedures. I understand that I can ask any questions that I may have about these policies, at any time.

___________________________	______________________________	__________
Signature of Staff Member	Signature of Client/Parent/Guardian	Date

Privacy Practices Policy:

I have received a copy of Northeast Ohio Behavioral Health, Ltd.'s Notice of Privacy Practices. I understand that I can ask any questions that I may have about these policies, at any time.

___________________________	______________________________	__________
Signature of Staff Member	Signature of Client/Parent/Guardian	Date