

Counseling Psychiatry



For Inte	rnal use
	Akron
	Seven Hills

Facility Name:	Patient Name:

Counseling and Psychiatry Consent

Services will be provided under the signed order of your Primary Care Physician and your consent.

Insurance payments will be made directly to 360care for covered services.

By signing below, you acknowledge that you:		
o Consent to an Intake Evaluation by 360care Counseling	ng and the delivery of services below.	
 Have been given the 360care Notice of Privacy Practic which you reside and posted on the company website 	•	in the facility in
 Have been given the Behavioral Medicine Description be given to the facility in which you reside and poster 	, ,	
o Agree that 360care Counseling and 360care Psychiatr	ry have the right to refuse services at their d	liscretion.
o Authorize 360care Counseling to complete an Expert	Evaluation, if requested.	
 Understand that counseling services may be provided of a psychologist. 	d by a mid-level provider who works under t	he supervision
 Assume responsibility for all allowable charges (dedu carrier and authorize payment be made directly to 36 	•	by the insurance
<u>Counseling</u> (Psychotherapy)	<u>Psychiatry</u> (Medication Manag	ement)
☐ (Yes) I CONSENT to Counseling services☐ (No) I DECLINE Counseling Services	☐ (Yes) I CONSENT to Psychiatry ☐ (No) I DECLINE Psychiatry Se	•
nature of Responsible Party:	Relationship:	Date

(Your signature signifies your request and consent to any service not checked as declined.)