CATHOLIC CHARITIES BLOOMINGTON

Consent for Mental Health Services

Name_____ Date of Birth_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Are we able to leave a voicemail at any number? _____

Please list full names of children:

Name_____ DOB_____ Name_____ DOB_____

Name_____ DOB_____ Name_____ DOB_____

Name_____ DOB_____ Name_____ DOB_____

Email Address_____

Emergency Contact/Phone Number_____ Relationship to client_____

Parent/Legal Guardian_____ Parent/Legal Guardian_____

Address_____ Address_____

City_____ Zip_____ City_____Zip_____

Phone Number_____ Phone Number_____

I am requesting mental health services for myself or my minor child listed above. I, the undersigned, agree and consent to participate in the mental health services offered and provided by the staff of Catholic Charities Bloomington. I understand that I am consenting and agreeing only to those mental health services that my provider(s) is (are) qualified to provide within the scope of each provider's license, certification, and training.
I understand that some services may be provided by non-licensed providers being trained as mental health professionals. All non-licensed providers have mental health training and are being directly supervised by a licensed mental health provider who is a staff person of Catholic Charities Bloomington and who takes full responsibility for the non-licensed provider's work. If my primary provider is unlicensed, this will be indicated by the signature and printed name of that provider's supervisor. You have the right to meet you provider's supervisor if you wish.

Please sign below if you have read, completed, and understood the above information.

_____ _____

Clients Signature Date Witness Date

_____ _____

Parent/Guardian Signature Date Witness Date