



Informed Consent for Care and Treatment

Personal Assistance Services
9735 Landmark Parkway, Suite 17
St. Louis, MO 63127
(314) 842-6223 OR (800) 356-0845

Please read each section carefully. Then print and sign your full name with the date at the bottom of the page.

CONSENT

The goal of my participation in counseling at Personal Assistance Services is to improve the outcome of personal concerns which may otherwise affect my quality of life. I hereby give my consent for assessment and consultation. I understand that the service is provided by a state-licensed mental health professional and may include:

- Completion of inventories and questionnaires;
- Evaluation of the nature and severity of my concerns and their impact on my quality of life;
- Recommendations by a licensed professional which may alleviate my concerns;
- Professional consultation based on treatment goals which have been mutually agreed upon by me and my consultant;
- Recommendations of activities, self-help assignments, and participation in community support services which are designed to further enhance the outcome of my situation;
- Referrals for additional consultation or care outside of PAS. I always make the final decision regarding whether or not to access these referrals. If I access services outside of PAS, I am responsible for any costs which may be incurred by these services and if I use my insurance, final verification of insurance coverage is my responsibility.
- Coordination of care with other medical and/or mental health providers who provide professional health care.
- The expectation by my consultant that I will actively participate in solving my problem by completing self-help assignments and taking action in my daily life.

I understand that PAS staff will only contact me as I specified during the intake process. My contact information is printed at the end of this Consent and has been verified by me.

I also acknowledge that I am free to discontinue my participation in services with Personal Assistance Services at any time.

CONFIDENTIALITY

Personal information about me and my situation will be kept strictly confidential and will not be released to anyone outside of PAS unless I give written permission to do so (except as required by law when a situation is life-threatening, child or elder abuse is occurring, to comply with a court order, or as necessary in the provision of treatment, payment and certain other administrative duties). I have read and/or received a copy of Personal Assistance Services' **Notice of Privacy Practices** which explains in detail my rights with respect to my health information, and PAS' obligation to protect it.

Client Name: _____

My address for all correspondence is: _____

Case ID: _____

Phone numbers:

Message OK?

Home

Work

Alternate

Signature (or legal guardian if under 18 years of age)

Date