



801 CASCADE POINT LN, CARY NC 27513 [NORTH CAROLINA]
4275 JOHNS CREEK PKWY, SUWANEE, GA 30097 [GEORGIA]
2603 AUGUSTA DR, HOUSTON, TX 77057 [TEXAS]
(919) 576-2607[GA] ♦ (470) 567-9073[GA] ♦ (346) 586-5732[TX]
INFO@INNERBALANCEDX.COM

Not just a diagnosis – a path forward.

CONSENT FOR TREATMENT

Consent for Behavioral Health Treatment

I voluntarily consent to receive services from Ascencia Behavioral Health DBA InnerBalance Diagnosis Center. Services may include assessment, therapy, psychiatric care, and related behavioral health services.

I understand:

- Treatment is collaborative and outcomes are not guaranteed
- I may withdraw consent at any time
- I have the right to ask questions and receive information about my care

Patient Name: _____

Signature: _____

Date: _____

Guardian (if applicable): _____

Signature: _____

FINANCIAL RESPONSIBILITY & BILLING AUTHORIZATION

Financial & Billing Agreement

I agree to be financially responsible for all services provided.

I authorize Ascencia Behavioral Health to:

- Charge my card on file for copays, deductibles, and balances
- Charge fees for missed or late-cancelled appointments
- Collect outstanding balances as permitted by law

I understand payment is due at the time of service unless otherwise arranged.

Patient Name: _____

Signature: _____

Date: _____

HIPAA & PRIVACY ACKNOWLEDGMENT

HIPAA Privacy Acknowledgment

I acknowledge that I have received or been offered the Notice of Privacy Practices.

I understand:

- My information may be used for treatment, payment, and operations
- I have rights to access, request changes, and limit disclosures

Patient Name: _____

Signature: _____

Date: _____

We look forward to supporting you on your healing journey

PLEASE EMAIL FORM TO INFO@INNERBALANCEDX.COM OR FAX TO (919) 935-085



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TELEHEALTH CONSENT

Telehealth Consent

I consent to receive services via telehealth.

I understand:

- Telehealth involves electronic communication
- There are risks (technical issues, privacy limitations)
- I must be in a private, safe location

In emergencies, I will call 911 or go to the nearest ER.

Patient Name: _____

Signature: _____

Date: _____

COMMUNICATION CONSENT

COMMUNICATION CONSENT

Consent to Electronic Communication

I consent to receive communications via:

- Phone
- Text
- Email
- Patient portal

I understand there may be privacy risks with electronic communication.

Patient Name: _____

Signature: _____

Date: _____

NO-SHOW & CANCELLATION POLICY

Appointment Policy Agreement

I understand:

- 24-hour notice is required for cancellations
- Late cancellations and no-shows may result in fees
- Repeated missed appointments may result in discharge

Patient Name: _____

Signature: _____

Date: _____

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CLINICAL HISTORY ATTESTATION

Medical & Mental Health History Acknowledgment

I confirm that the information I provide regarding my medical, mental health, and medication history is complete and accurate to the best of my knowledge.

Patient Name: _____

Signature: _____

Date: _____

EMERGENCY & LOCATION CONSENT

Emergency & Location Agreement

I agree to:

- Provide my location during telehealth sessions
- Provide an emergency contact

I understand emergency services may be contacted if needed.

Patient Name: _____

Signature: _____

Date: _____

INTERSTATE CARE DISCLOSURE

Interstate Telehealth Disclosure

I understand services are only provided if I am located in a state where my provider is authorized to practice. I agree to accurately disclose my location.

Patient Name: _____

Signature: _____

Date: _____

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CONSENT TO TREAT A MINOR

Consent for Treatment of a Minor

I certify that I am the legal parent/guardian and authorize treatment.
Documentation may be required for custody or guardianship.

Minor Name: _____

Guardian Name: _____

Signature: _____

Date: _____

RELEASE OF INFORMATION

Authorization to Release Information

I authorize Ascencia Behavioral Health to share information with:

Entity: _____

Purpose: _____

I understand I may revoke this authorization at any time.

Patient Name: _____

Signature: _____

Date: _____

SPECIALIZED TREATMENT CONSENT

Specialized Treatment Consent

I understand additional therapies may include:

- EMDR
- Somatic therapies
- Group or family therapy
- Functional Medicine therapy

Risks, benefits, and alternatives have been explained.

Patient Name: _____

Signature: _____

Date: _____

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ATTENDANCE & PARTICIPATION AGREEMENT

ATTENDANCE AGREEMENT

I agree to attend sessions regularly, arrive on time, and participate in treatment.

Patient Name: _____

Signature: _____

Date: _____

RESEARCH & FEEDBACK CONSENT

Research & Satisfaction Consent

I understand:

- Participation in research is voluntary
- I may receive satisfaction surveys

My care will not be affected if I decline.

Patient Name: _____

Signature: _____

Date: _____

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