# iAMERICA WELLNESS — Full Intake Packet

## 1️⃣ Consent to Treat a Minor

**Minor's Name:** _____ **Date of Birth:** _____ **Parent/Guardian Name:** _____ **Relationship to Minor:** _____

I, as the parent or legal guardian of the above-named minor, voluntarily consent for the minor to receive services from iAMERICA WELLNESS, which may include:

- Psychological and diagnostic evaluations
- Individual, group, or family therapy
- Psychiatric or medical consultation
- Supportive or skill-building services
- School or community coordination

☐ I affirm that I have full legal authority to provide this consent (documentation available upon request)

**Parent/Guardian Signature:** _____ Date: _____ **Minor Signature (if age 14+):** _____ **Staff/Witness Signature:** _____

## 2️⃣ Consent for Co-Occurring Mental Health & Substance Use Services

**Client Name:** _____ **Date of Birth:** _____

I consent to receive services that address both my mental health and substance use needs, including:

- Co-occurring treatment and therapy
- Recovery support and relapse prevention
- Psychiatric or medical care

- Case management or peer-based services

I understand that:

- My care team may share information internally to coordinate services
- Substance use information is protected by 42 CFR Part 2 and requires specific consent to release
- I may withdraw this consent in writing at any time
- This consent supports integrated treatment based on my needs

☐ I authorize internal information sharing between: ☐ Therapist ☐ Case Manager ☐ Substance Use Counselor ☐ Psychiatrist/Medical Provider ☐ Peer Recovery Coach ☐ Other: _____

**Client Signature:** _____ Date: _____ **Staff Signature:** _____

## 3️⃣ Guardian Authorization for Services

**Client Name:** _____ **Date of Birth:** _____ **Guardian Name:** _____ **Relationship to Client:** _____

I affirm that I have legal authority to consent to services for the above-named client and have provided or will provide documentation if required.

I authorize iAMERICA WELLNESS to provide behavioral health and support services including:

- Psychological assessments
- Mental health or dual-diagnosis therapy
- Medication review and psychiatric consultation
- Life skill-building or peer-based support
- Emergency planning and coordination with external agencies

☐ Legal documentation of guardianship is attached / available upon request

**Guardian Signature:** _____ Date: _____**Staff Signature:** _____Date:_____

## 4️⃣ Authorization to Release or Obtain Information (ROI)

**Client Name:** _____ **Date of Birth:** _____

I authorize iAMERICA WELLNESS to: ☐ Release information to ☐ Obtain information from ☐ Exchange information with

**Name of Individual or Agency:** _____ **Purpose of Disclosure:** ☐ Treatment coordination ☐ Legal / Forensic ☐ Benefits/Eligibility ☐ Client Request ☐ Other: _____

**Information to be Shared (check all that apply):** ☐ Mental health records ☐ Substance use treatment records (42 CFR Part 2) ☐ Medication or medical information ☐ Psychological evaluations ☐ Education or employment records ☐ Legal or court documents ☐ Full client chart ☐ Other: _____

Effective From: _____ To: _____ ☐ I understand that I may revoke this authorization at any time in writing

**Client/Guardian Signature:** _____ Date: _____**Staff/Witness Signature:** _____

## 5️⃣ HIPAA Privacy Practices Acknowledgment

**Client Name:** _____ **Date of Birth:** _____

I acknowledge that I have received or been offered a copy of iAMERICA WELLNESS's Notice of Privacy Practices. I understand how my health information may be used or shared and my rights under HIPAA.

**Client/Guardian Signature:** _____ Date: _____ **Staff Signature:** _____

# 📱 Telehealth Services Consent

**Client Name:** _____ **Date of Birth:** _____

I consent to receive services from iAMERICA WELLNESS via telehealth, including phone, video, or secure virtual platforms.

I understand that:

- Telehealth sessions will be conducted privately and securely
- Confidentiality will be maintained to the best extent possible using current technologies
- I may withdraw this consent and request in-person sessions at any time
- I am responsible for ensuring privacy on my end during sessions

**Client/Guardian Signature:** _____ Date: _____ **Staff Signature:** _____