RUSH UNIVERSITY MEDICAL CENTER
Department of Psychiatry
AMBULATORY BEHAVIORAL HEALTH

Admission Consents and Releases

Initials: _____  Consent for Admission and Treatment
1. I am voluntarily requesting diagnosis and treatment for a condition from which I am (my ward is) suffering.

2. I understand that this treatment will involve various diagnostic test(s) *, procedures **, and care under the direction of Dr. ____________________, resident physicians in training, assistants, or designees as is necessary in my (my ward’s) physician's judgment.

3. I acknowledge that no guarantees have been made or expressed to me as to the result(s) of treatment or examinations in this facility.

4. This form has been fully explained to me and I certify that I understand its contents.

* Diagnostic tests may include: Psychological testing, laboratory tests, medical or clinical examinations, and a breathalyzer and/or urine for drug screening may be done upon admission and may be done during treatment if use is suspected.

** Procedures may include: Individual, Group, or Family Therapy. Medication Management, medical screening, History & Physical, educational presentations and experiential workshops.

Initials: _____  Consent for Emergency Care
In the event of an emergency, I hereby give my consent for Rush University Medical Center Department of Psychiatry Ambulatory Behavioral Health Staff to provide the staff of a local hospital with information necessary to provide me with such diagnostic assessment(s) and treatment(s) the emergency room physician deems necessary in the event that I am incapacitated due to illness, injury or accident while a patient within the Rush Department of Psychiatry Ambulatory Behavioral Health Program(s).

It is also my wish that the following person be contacted:

Name of person to contact in an emergency: __________________________________________

Relationship to the patient: ________________________________________________________

Phone: (Home) __________________________ (Work) _______________________________

Initials: _____  Receipt of Patient Rights
I have received a copy of the program’s policies regarding Patient Rights and guidelines. I have also been provided with a written notice of my rights under the Federal Confidentiality Act. Additionally I have been provided with a patient handbook, which provides general information about the program and services including the general nature and goals of the program and its hours of operation.

Initials: _____  Receipt of Notice of Privacy Practices
I hereby acknowledge receipt of the Notice of Privacy Practices.
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I hereby acknowledge that the previous consents and releases have been fully explained to me. I have initialed each one showing my agreement with the consent or release as stated.

Patient Signature: ________________________________ Date: ________________

Witness Signature: ________________________________ Date: ________________

If this acknowledgment is by someone other than the patient (a personal representative*) please complete the following:

Personal representative’s name: ______________________________________________________

Personal representative’s signature: ___________________________________________________

Relationship to patient: ________________________________ Date: ________________

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If unable to obtain written acknowledgment of receipt of the notice of privacy practices, document good-faith efforts to obtain acknowledgment and the reason why the acknowledgment was not obtained below:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Staff Signature: ________________________________ Date: ________________