Treatment Consent and Confidentiality Consent

This information sheet acquaints you with our office policies and procedures. Please read and sign or initial, as indicated, below on this form.

EMERGENCIES: If you have an emergency situation your behavioral healthcare professional will instruct you on how to leave confidential messages and page him or her in an emergency.

TREATMENT:

- I authorize treatment of myself or the dependent indicated as the patient.
- I understand my Practitioner will discuss my individual treatment with me; together we will revise my treatment plan as necessary.
- I understand that if my behavioral healthcare Practitioner requests authorization for additional sessions from my managed care company, the medical necessity for further treatment and the effectiveness of treatment already provided will be weighed.
- I authorize the release of information necessary in order to process claims with my payor.
- My signature indicates I have read and I understand these procedures regarding treatment.

Patient's or Legal Guardian's Signature	Date	Patient's Printed Name

CONFIDENTIALITY:

To protect your best interests and personal rights, we would like you to be aware that professional ethics and law dictate whatever you say in a psychotherapy session will remain confidential and will not be shared with anyone without your written permission. The following are exceptions to this confidentiality and may be clarified with your Practitioner.

- If you report to your Practitioner any knowledge of child, elder, or dependent abuse, your Practitioner may **be** required by law to report it to the authorities or child protective services.
- If you indicate that you intend to harm yourself or anyone else, your Practitioner must take reasonable and precautionary measures to protect whomever is in danger.
- Brief written records are kept regarding your treatment goals and progress. Certain situations may arise where the records are subpoenaed by a judge. We may be compelled to surrender them. This may occur when you become involved in a legal situation in which your psychological state is an issue.
- If you are under the age of 18, your parents or legal guardians have the right to be informed of your psychological condition, progress, and treatment goals.

YOUR SIGNATURE BELOW INDICATES THE FOLLOWING: I have read and I understand these confidentiality procedures.

- If you have been referred to us by an agency, HMO, PPO, or other third party payor, we are usually required to furnish information to that agency. Your signed agreement with them gives them permission to request information.
- I authorize my Practitioner to furnish information to my third party payor concerning my psychological treatment in order to process payments and benefit utilization.
- I authorize communication among my attending healthcare Practitioners for coordination of care. I authorize my behavioral healthcare professional to communicate the above-mentioned confidential information in person, by telephone, by written material, or by facsimile. I release the source of these records from any liability arising from their release.
- Clinical information may be sent in a written report to your Primary Care Physician (PCP). This communication is important for the coordination of your care. The Practitioner must first obtain your signature approving this written communication.
- I understand that my records may be reviewed by representatives of my payor to assure compliance with Quality of Care standards.
- I understand that I have the right to formally appeal decisions regarding authorized treatment *services.*
- I further understand that I have the right to submit a complaint or grievance regarding any aspect of my care. I understand that I risk nothing in exercising these rights.
- A photocopy of this release is to be considered as valid as the original.
- This authorization is subject to revocation by me at any time except to the extent that action has been taken in reliance hereon.

Patient's or Legal Guardian's Signature	Date	Patient's Printed Name

Patient's SS#