Family Health Care --- Consent to Treatment for Adult

I acknowledge that I have received, have read (or have had read to me), and understand the “Family Health Care Behavioral Health Program Orientation" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in outpatient counseling at the Family Health Care program. I understand that participating in an initial evaluation, developing a treatment plan, and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by my assigned therapist/program. I am aware that I may stop my treatment with my assigned therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I may be discharged from treatment due to non-participation.

I understand that Federal laws and regulations protect my health information to that extent afforded by the laws (See 42 U/S.S. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations.) Exceptions to this law or instances when your information may be released include:

- Written Consent by the client
- Internal Communications within the agency, as necessary
- Medical Emergencies
- Court Order
- Crime at Program/against program personnel
- Research with no client-identifying information
- Audit and Evaluation by external agency/entity as required for licensure/accreditation
- Suspicion of Abuse and/or Neglect against a Child or vulnerable Adult
- A Qualified Service Organization/Business Associate Agreement
- Insurance Company or 3rd party payer for billing purposes.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy Declined by client ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.