INFORMED CONSENT FOR TREATMENT

I have received the Patient Information Packet from Medpsych Health Services, LLC, (Medpsych) which includes information regarding access, fees, Patient Rights and Responsibilities and Privacy Practices. I accept these policies and practices. I have been given the opportunity to review both, "Rights and Responsibilities" and "Privacy Practices" which are available on the Medpsych website at http://www.medpsychmd.com. I understand I may print them from the website or request a copy of these notices if I wish to keep them for my personal reference.

I understand that behavioral health treatment offers no guarantees. By working with my doctor, therapist, and/or counselor, I should get help with the problems and concerns I bring to Medpsych Health Services, LLC. However, I recognize that things may get worse. I understand that I will probably need to do homework—that is, try new ways of dealing with my problems—which I develop together with my doctor or therapist. If I do not do these things outside the office, I understand that the effectiveness of treatment will be limited.

I agree to cooperate fully with my doctor, therapist, and/or counselor or to discuss with him or her any reasons why I cannot. I agree to ask any questions I have to clarify my treatment goals and how therapy and or treatmentis addressing them.

I understand that treatment will end when the problems and concerns I initially had are resolved. I also understand that I can terminate my treatment at any time I wish. I agree to notify my doctor,therapist or counselor of my intent to end therapy and to discuss the possible risks of premature termination of therapy.

I also understand that my therapist, doctor or counselor may end my treatment if we do not make progress, or if our relationship becomes too strained to continue working together. If I am no longer able to pay for services and treatment is to be terminated early, my therapist, counselor or doctor will make suggestions to guide me in finding another provider of my choice. I will make every effort to follow the suggestions.

_____ ____/_____/____

Patient/Guardian Signature Date

If patient is a minor:
By signing above, I certify that I have full legal custody and rights to consent for treatment.

* **If patient is minor and legal custody is joint,** Medpsych Health Services requires signatures from both parties.