CONFIDENTIAL
INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name:_____ Date of Birth:_____ ID #:_____

I understand that as a subscriber to the Community Medical Center (CMC), I am eligible to receive a range of services at the facility. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks**.**

Please Note: We reserve your appointment time for you, we may charge a fee up to and including our full normal fee, for missed appointments not cancelled at least 24 hours in advance.

I understand that all information shared with the clinicians and medical staff is confidential and no information will be released without my consent. During the course of treatment at CMC, it may be necessary for my therapist to communicate with other providers at the CMC. While written authorization will not be requested prior to any discussion with other providers, I understand that my therapist will discuss intrafacility communications with me. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child/elder, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that a range of mental health professionals provide CMC services. All professionals-in-training are supervised by licensed staff. I understand that while psychotherapy and/or medication, may also provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects. If I have any questions regarding this consent form or about the services offered at CMC, I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by CMC. I understand that I may stop treatment at any time.

_____ _____

Signature Date