Wellspring Center, PLLC
1995 NC Hwy 172 Suite B
Sneads Ferry, NC 28460
Phone: 910-327-0800
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Patient Consent for Treatment

I am requesting evaluation and/or treatment for ____ at
Patient Name
Wellspring Center, PLLC. If after evaluation, it is determined that further treatment is appropriate, I hereby consent to such treatment as is deemed necessary by clinicians at Wellspring Center, PLLC.

While I expect benefits from this treatment, I fully understand that benefits and outcomes cannot be guaranteed. I also understand that patients undergoing counseling or therapy may experience emotional stress, may feel worse at times during treatment and may make life changes which could be distressing.

I understand that regular attendance will produce the maximum benefits but I am free to discontinue treatment at any time. If I decide to do so, I will notify the clinician at least two weeks in advance so that effective planning for continued care can be implemented.

I understand that this office will maintain sufficient records to provide thorough and appropriate treatment. I understand that conversations with clinicians and information I provide to this office is confidential and that release or disclosure of any identifiable information to any individual or agency is prohibited except as allowed by my written authorization or as outlined in the Notice of Privacy Practices, a copy of which has been provided to me and is available online. I understand that disclosure of information by this office for the purpose of legal proceedings for marital separation/divorce and obtained during the course of marital counseling is prohibited by law. I understand that the law requires disclosure under certain situations such as those that involve potential harm to self or others. I understand that the clinician must maintain compliance with the law but will make reasonable efforts to resolve emergent situations before breaking confidentiality.

I understand that the clinician is not providing an emergency service, and I have been informed as to the procedure to follow in the event of an emergency during non-business hours. I also understand that charges for weekend or after-hours therapeutic services are billed at a higher rate than appointment-based services and may not be covered by my insurance plans.

I understand that appointments may be canceled up to 24 hours in advance of the scheduled appointment, and that cancellation of appointments less than 24 hours in advance, as well as missed appointments, may incur a “no-show” fee, which is not covered by insurance plans.

I understand that I will be financially responsible for this treatment and for any portion of fees or charges not reimbursed or covered by my health insurance. I know of no reasons not to undertake this therapy and I agree to participate voluntarily.

____________________________________	____________________________________
Print Name of Patient	Print Name of Legal Guardian if applicable
____________________________________	____________________________________
Signature of Patient or Legal Guardian	Date
____________________________________	____________________________________
Witness	Date