PACIFIC BEHAVIORAL HEALTH CARE
CONSENT TO TREATMENT

This form is to document that I, _____, give my permission and consent to the above named professional to provide behavioral health treatment(s) to me.

While I hope for benefits from this treatment, I fully understand that because of factors beyond anyone's control or other factors, such benefits and particular outcomes cannot be guaranteed. I understand that because of the treatments, I may experience emotional strains, feel worse during treatment, and make life changes which could be distressing.

I understand that PACIFIC BEHAVIORAL HEALTH CARE (PBHC) and its associates are not providing and will not provide emergency services. I understand that in an emergency I am to make an appointment with a PBHC professional for a later date/time, contact my physician or psychiatrist, go to the emergency room, or call 911.

I understand that regular attendance will produce the maximum possible benefit but that I am free to discontinue treatment at any time. If I decide to do so, I will notify the treatment professional(s) in advance so that effective planning for continued care, if needed, can be implemented.

I understand that conversations with the treatment professional(s) will almost always be confidential. I further understand that the therapist, by law, must report actual or suspected child or elder abuse to the appropriate authorities. The treatment professional(s) may have a legal responsibility to protect anyone I may threaten with violence, potentially harmful or dangerous actions (including those to myself), and may break confidentiality of our communications if such a situation arises.

I understand that I am financially responsible for this treatment and for any portion of the fees not covered or reimbursed by my health insurance. I also understand that I am responsible, not PBHC, to become knowledgeable about the coverage provisions of my insurance policy. PBHC will be happy to bill your insurance company for you and follow up on any challenges to the claim. There is a monthly fee of $25.00 for this service. By initialing here _____ I instruct PBHC to take care of the billing for me and agree to be responsible for the $25.00 monthly fee. If I do not wish to avail myself of this service, PBHC will provide me with a super bill which will have all the information necessary for me to seek reimbursement directly from my insurance company and follow up if needed.

I know of no reasons I should not undertake this therapy and I agree to participate fully and voluntarily.

Signature: _____ Date: _____
(Of patient or person authorized to consent for patient)