Consent for Treatment

Name of Patient:_____ Date of Birth ____/____/____

Parent name (if Pt is a minor) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Health Insurance Plan: _____ Member ID number: _____
Please provide a copy of your insurance plan card (front and back)

CLIENT CONSENT

In order to consent to mental health treatment, you need to know the following information. This document is for the client *or* for the parent/guardian of a minor (child/adolescent).

***IMPORTANT*: PLEASE COMPLETE THESE INSTRUCTIONS FOR CONTACTING YOU:**

I wish to be contacted as follows (check all that apply):

[ ] At my home number:_____ [ ] OK to leave a message

[ ] At my work number: _____ [ ] OK to leave a message

[ ] At my cell number:_____ [ ] OK to leave voicemail message / TEXT

EMERGENCY CONTACT:

In the event that I cannot be contacted via any of the above phone numbers and addresses, OR in the event of an emergency, I give permission for Minette LCSW Psychotherapy Services staff to contact my emergency contact:

Name:_____ Phone Number:_____

Voluntary, Informed Consent to Treatment- My signature below indicates voluntary consent for evaluation or evaluation and treatment for myself or, if the client is a minor, for that minor (child/adolescent). If the client is a minor, I attest I am the legal guardian of the minor and have the right to consent to evaluation or evaluation and treatment for this minor. This consent applies to all providers at Minette LCSW Psychotherapy Services who may provide services and permits the sharing of information amongst Minette LCSW Psychotherapy Services staff in order to facilitate the best treatment plan for my care, and/or assist in the event of a clinical emergency.

2969 GRAND CONCOURSE, SUITE L2, BRONX NY 10458
Phone: 201.724.5489 Fax:914.346.5031
minettetherapy@gmail.com

Duration of Consent- I understand that consent expires when I am no longer a client at Minette LCSW Psychotherapy Services unless this consent is revoked by providing a written request to my provider. I understand this consent is for evaluation or treatment and does not include participation in research.

Emergency Care- In case of an emergency, I understand Minette LCSW Psychotherapy Services staff reserves the right to contact 911 if my therapist has assessed that I am undergoing a life threatening emergency, or that I am at risk of harming myself or others. Minette LCSW Psychotherapy Services staff reserves the right to advise emergency personnel (EMS) regarding my needs at that time.

Limits to Confidentiality- The information I give to my provider is generally confidential and will only be released outside of Minette LCSW Psychotherapy Services with my written permission (or with the permission of a parent or guardian of a minor). However, I acknowledge these limits to confidentiality under New York State & Federal Statutes: a) The therapist may use information within Minette LCSW Psychotherapy Services and with its business associates for treatment, payment, and other health care operations. b) The provider is usually required to answer certain subpoenas or court orders, to report threats of homicide or suicide, to report the suspicion of child abuse or child neglect, and may report elder abuse or abuse of a handicapped person or a crime which may occur in the future.

Limited Disclosures- All disclosures will be made to the appropriate parties as directed by law, such as authorities, parents of minors, or intended victims of violence. When the provider must release information without your consent, the information revealed will be limited to what is necessary to protect you or to protect others, or the limited information necessary for collection of a past due bill, or the information ordered to be released to the court. When information is released with your consent, we will release the information you request us to disclose.

Informed Consent- I understand I have the right to make an informed decision about treatment. A Minette LCSW Psychotherapy Services staff has provided an explanation of this consent, the limits of confidentiality, and the fees/ cost for my treatment.

I hereby give consent for evaluation and/or treatment by the clinical staff at the Minette LCSW Psychotherapy Services staff.

Patient Signature:_____
Date:____/____/_____

Name of Parent/Legal Guardian:_____

Parent/Legal Guardian Signature:_____
Date:____/____/_____

Staff / Witness Signature: _____
Date:____/____/____

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