PATIENT REGISTRATION

Pinellas: 3840 5TH Ave N Saint Pete FL 33713 **Phone:** 727-367-2273 **Fax:** 727-800-6929 **Pasco:** 7340 Little Rd New Port Richie FL 34654

CONSENT FOR TREATMENT

I _____voluntarily consent that I will participate in a behavioral health treatment mental health services for myself and/or my child by staff from Caring Community Counseling. Treatment may be provided by a master's level counselor, a licensed therapist, a psychiatric nurse practitioner, a psychiatrist, or an individual supervised by any of the professionals listed. Services may include interviews, assessment or testing, psychotherapy, and/or medication management. I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

NATURE OF MENTAL HEALTH SERVICES

I understand that during treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

COMPLIANCE WITH TREATMENT PLAN

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

CLIENT RIGHTS

- The right to be treated with dignity and respect by all staff
- The right to be involved in the planning and/or revision of my treatment plan
- The right to know about my treatment progress or lack thereof
- The right to reject the use of any therapeutic technique, and to ask questions at any time about the methods used
- The right to be spoken to in a language that is fully understood
- The right to a clean and safe environment
- The right to refuse to be videotaped, audio recorded, or photographed
- The right to end treatment at any time unless court ordered
- The right to file a complaint or grievance about the agency or staff
- The right to confidentiality of clinical records and personal information according to federal and state laws

NOTICE OF PRIVACY PRACTICE

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make on your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. You may obtain a copy of our notice of privacy practices at your request.

COORDINATION OF CARE

Caring Community Counseling collaborates with client's primary care physician and last mental health provider. Please document name and phone number(s) _____

EMERGENCIES AFTER HOURS

I understand I may reach Caring Community Counseling provider at 727-367-2273. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life-threatening emergency, I may call 911.

Client Sign/date_____ **Staff Sign/Date**_____