

CLIENT CONSENT TO TREATMENT & TO RELEASE OF INFORMATION

CONSENT TO TREATMENT: We cannot provide consultation or treatment without your written consent.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: Comprehensive Psychiatric Associates (CPA) is committed to safeguarding the privacy and confidentiality of your health care information. Our policies regarding how we may use and disclose health care information are described in full in our Notice of Privacy Practices, available from the receptionist or from our web site (www.WellPsych.com). CPA uses and discloses (shares) health care information for many different reasons. For some of these uses and disclosures, we will need to obtain prior written authorization (permission) from you. However, CPA may also use or disclose your health care information for treatment, payment, and health care operations without obtaining prior authorization from you. For example, we may release information without your authorization to any insurance company or other entity responsible for payment for mental health services, to your primary care physician and to any other mental health care clinician participating in your treatment, and to employees and staff of CPA, for the purpose of providing care and treatment or of obtaining payment or authorization for payment from third-party payers.

You have the right to request, in writing, that CPA restricts how it uses and discloses your health information for the purposes of treatment, payment, or health care operations. CPA is not required by law to grant your request. However, if CPA does decide to grant your request it must adhere to the approved restrictions unless it is an emergency situation or it is in direct conflict with state or federal laws and regulations.

If you wish to further restrict the release of health care information, please indicate by writing your initials in the spaces to the left below:

_____ *I request that CPA not release health care information to my Primary Care Physician or to other mental health clinician(s) participating in my treatment, except in the case of a medical emergency.*

_____ *I request that CPA not release health care information to my health insurance company. (Please note: If you initial here, we will require full payment of all charges at the time of each visit.)*

I request that release of health care information be further restricted as follows:

I hereby consent to the rendering of care and service by CPA and its clinical staff for myself or for the client named below.

I have read the above and affirm that everything in this document that was not clear to me has been explained to my satisfaction. I acknowledge that I have had the opportunity to review CPA's Notice of Privacy Practices.

Signature of Client

Name of Client, Printed

Signature of Parent or Legal Guardian

Name of Parent or Legal Guardian, Printed

Relationship to Patient: father mother other _____
(Parent only may sign for 15 years old or younger. Patient & parent must sign for 16 or 17 years old.)

Signature of Parent or Legal Guardian

Name of Parent or Legal Guardian, Printed