Perspectives Treatment Center, Inc.

Consent to Treatment and Recipient's Rights

Client_____ Chart #_____

I, _____ (<<< print client name) hereby attest that I have Voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at Perspectives Treatment Center, Inc., hereby referred to as the PTC. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. PTC encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Client Notice of Confidentiality: The confidentiality of patient records maintained by PTC and their authorized clinicians and Medical Billers, are protected by federal and/or state law and regulations. Generally, PTC may not say to a person outside PTC that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) the patient consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

BILLING CONSENT: I assign payment for the charges for services rendered to either myself or any of those for whom I am financially responsible to Perspectives Treatment Center, Inc. I understand that I am responsible for any health insurance deductible and coinsurance for and in consideration of services rendered to the patient named above, I the undersigned agree to pay the full amount due. I grant permission to Perspectives Treatment Center, Inc, to furnish my relevant clinical information to their Professional Healthcare Billing Services in effort to bill and collect payment from my insurance/managed care organization.

Non-voluntarily Discharge from Treatment: A client may be terminated from the Center non-voluntarily. if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Clinic Director or request to reapply for services at a later date.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient's Rights Advisor.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above-stated policies and agreements with PERSPECTIVES TREATMENT CENTER, INC.

_____ _____

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)\

_____ _____

Witness Date