Hope Counseling
CENTER OF SAVANNAH

Informed Consent for Treatment

Patient Name: _____ Date: _____

I, _____, agree and consent to participate in behavioral/mental health care services offered and provided at/by The Hope Counseling Center. I understand that I am consenting and agreeing only to those services that the above-named center is qualified to perform within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral/mental health providers directly supervising the services received.

Signature: _____ Date: _____

Confidentiality

The staff of The Hope Counseling Center is dedicated to keeping information shared within your sessions private and confidential. In the event that we are billing a third-party, we must provide certain information concerning services rendered, diagnosis and you or your child's identity. If requested to release information with other entities/agencies, we will require a written consent.

Limits of Confidentiality

The following limits to confidentially apply:

1. We are required by law to report suspicions of child physical and /or sexual abuse or neglect
2. We are required by law to report homicidal or suicidal intent.
3. In the event of subpoena by a court, we are required to provide requested documents

Please ask for clarification if you misunderstand anything you have read in this material. Your signature below indicates that you have read and fully understand this document.

Signature:_____Date:_____

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary.

I authorize The Hope Counseling Center to release information about me, which may be necessary to my insurance company regarding services, which may be covered by my policy. Insurance payments, if any, will be made directly to the The Hope Counseling Center. A copy of this authorization may be used in the place of the original.

Signature:_____Date:_____

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Member's Rights and Responsibilities Statement of Member's Rights:

- Be treated with dignity and respect
- Fair treatment; regardless of race, religion, gender, ethnicity, age, disability or source of payment
- Treatment and other member information kept private. Only when permitted by law, may records be released without member permission.
- Easily accessed timely care in a timely fashion.
- Know about treatment choices. This is regardless of cost or insurance coverage by a member's benefit plan.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about clinical guidelines uses in providing and managing care.
- Ask their provider about their work history and training.
- Give input on the Member's Rights and Responsibility policy.
- Give input on the Member's Rights and Responsibilities policy
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and learn how to do so.
- Know of their rights and responsibilities in the treatment processes.
- Receive services that will not jeopardize their employment.
- Request certain providers.
- Have provider decisions about their care made without regard to financial incentives.

Statement of Member's Responsibilities:

- Treat those giving them care with dignity and respect.
- Give providers information they need, this is to ensure that providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The treatment plan is to be agreed upon by the member and the provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given by them by others.
- Keep their appointments. Members should call their provider as soon as they know they need to cancel visits.
- Let their provider know about problems with paying fees.
- Report fraud and abuse.
- Openly report concerns about the quality of care they receive.

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Signature Form

Patient Name: _____

Date: _____

I, (parent/guardian if patient is under 18), acknowledge that I received a copy of the Member's Rights and Responsibilities Statement as well as the Informed Consent policy. Please ask for clarification if you misunderstand anything you have read in the material. Your signature below indicates that you have read and fully understand these documents.

Signature: _____

Date: _____