PATIENT'S/CLIENT'S INFORMED CONSENT

I have chosen to receive treatment services through Child Psychiatry Associates, PC (CPA). My choice has been voluntary and I understand that I may terminate treatment at any time.

I understand that psychotherapy and the management of medication is a cooperative effort between my treatment provider and me. I will work with my treatment provider in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which may be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that confidentiality of records of information collected about me will be held or released in accordance with applicable state and federal laws regarding confidentiality of such records and information. .

I understand that state and local laws may require that my treatment provider report cases of actual or suspected abuse or neglect of minors or the elderly.

I understand that state and local laws may require that my treatment provider report cases in which there may exist a danger to others or myself.

I understand that there may be other circumstances in which the state or federal law may require my treatment provider to disclose confidential information.

I have read and understand the Informed Consent agreement with the treatment provider of Child Psychiatry Associates, PC.

I understand that my treatment provider may disclose any and all records pertaining to my treatment to my insurance company and my primary care physician, if such disclosure is necessary for claims processing, case management, coordination of treatment, quality improvement or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. If I do not revoke this consent, it will expire automatically upon the earlier of 6 months from the date I signed this Informed Consent or 6 months after all claims for my treatment have been paid as provided in my benefit plan.

I have read and understand the above.

_____

Client's Signature Date

_____

Signature of Parent, guardian, conservator Date
Or authorized representative (when required)

_____

Witness' Signature Date

(over)