Serenity Mental and Medical Health Care

"Because you are alive, everything is possible."
— Thich Nhat Hanh

CONSENT TO TREATMENT

First Name _______________ Last Name _______________

You are about to take a very important step in your mental wellness plan, and you are seeing a mental health professional. As your mental health provider, we will be entering into a protected relationship. Treatment might involve a multidimensional family approach. Due to this consent is needed for all those attending sessions.

We are treating you and we will do our best to accurately diagnose you and design a comprehensive treatment plan that will enable you to continue with a normal emotional development. This may include recommendations of therapy, or medications. This is all part of the service of a mental health professional. We will also work with your primary care physician to assure coordination of care.
__________ **(Initial)**

You are our client and have confidentially rights. Confidentiality does not apply under certain situation: We are obligated by law to report any suspicion of child abuse. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of killing themselves or has made threats to hurt someone else. Except in these rare situations, your child has the right to keep particular topics confidential from even his/her guardian. Please respect this confidentiality. Again, if there is any concern of harm, suicide or other dangerous behavior, we will inform you.

If I require or think it is in your best interest to communicate with an outside source, I will request a release of information. To assure good therapeutic care, frequent appointments are required. Unless arranged otherwise, clients that have not been seen in 2 months will be considered inactive. A new evaluation will be required for any inactive client to be seen.
__________ **(Initial)**

I, ________________________________ (client), do hereby seek and consent to take part in the treatment provided by Serenity Mental and Medical Health Care/Harmony Within . If I am attending group services I also understand and consent that confidentiality still applies and that Serenity Mental and Medical Health Care/Harmony Within is not liable for group members breaking confidentiality. I understand that developing a treatment plan with this provider and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process.I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this mental health professional.

__________ **(Initial)**

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I am aware that I may stop treatment with this mental health professional at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

__________ **(Initial)**

I am aware that if I attempt to contact my provider through phone, email, text, or any other form of communication over the Internet, my information may not be completely secure. If my information is intercepted, Serenity Mental and Medical Health Care/Harmony Within is not responsible for the breach of patient privacy. Below are the approved contact means to leave messages on or respond to if contacted:

Phone ______________________ Email ______________________

__________ **(Initial)**

Patient Name (please print) ______________________

Patient Signature ______________________ Date __________