Family Guidance Centers
CHESTERFIELD • POWHATAN

Consent for Treatment (Please complete section **A** or **B** and sign below as indicated)

A. I, _____ (patient name), the undersigned, do voluntarily consent to behavioral health assessment and/or treatment for myself by _____ (FGC Therapist).
OR

B. I, _____ (parent/guardian name), the undersigned, am the legal guardian of _____ (child's name), _____ (date of birth), a minor child. I do voluntarily consent to his/her behavioral health assessment and/or treatment by _____ (FGC Therapist).

Consent For Treatment

- I understand that like the other healing arts, behavioral health is not an exact science and no guarantees are being made as to the results of assessment and/or treatment.
- I am aware that I am an active participant in this endeavor and that I share the responsibility for the treatment process.
- I understand that assessment and/or treatment will be kept confidential with the exception of legal limitations of confidentiality. In addition, I am aware that although the above-named therapist is clinically independent, consultations with other therapists are sometimes advisable, and my signature below gives the above-named therapist permission to do that. I further understand that there are specific and limited exceptions to this confidentiality which include the following:
  - When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
  - When there is suspicion that a child or elder is being abused or is at risk of such abuse, the clinician is legally required by Virginia State to take steps to protect the child, and to inform the proper authorities.
  - When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.
- I understand that when the above named therapist is unavailable, another behavioral health provider may be providing emergency coverage. I understand that the therapist providing coverage may be given access to relevant information in order to provide the best interim care possible.
- I authorize the release of any information necessary to process any insurance claims. This would include an ongoing release of information to meet managed care review requirements.
- If you are a member of a Managed Care Organization a "Members Rights and Responsibilities" document may be available to you.
- FGC has provided me with the opportunity to read the Notice of Privacy and all of my questions have been answered.
- You have the right to revoke this consent in writing and terminate services with the above named therapist at any time. In that event, your therapist or FGC staff is willing to help you locate alternative resources in the community.

I have read and understand the information on this sheet. My signature indicates my informed consent with the above-named therapist. If you have any questions about the form, please discuss them with your therapist.

_____ _____ _____
Signature Relationship to Patient Date

In order to provide the best care possible, your therapist would like to be able to communicate with your Primary Care Physician (PCP). Many insurance companies require this information.

Please **check** one of the following: **I DO** ____ or **I DO NOT** ____ give FGC permission to exchange my protected health information or my child's protected health information with our PCP.

_____ _____
Signature of Patient or Parent/Guardian Date

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