

GENERAL CONSENT TO TREAT

I, the undersigned, hereby request and consent to treatment rendered by the below-named PsychHealth member physician or clinician. I understand that this consent is for voluntary treatment on an out-patient basis. I understand that as a voluntary out-patient, I am free to review my treatment plan, and that if I disagree with any aspect of it my clinician will try to offer an acceptable alternative treatment plan. Should he/she insist that no reasonable alternative exists and I still refuse the recommended treatment, I understand that my clinician may elect to withdraw his services or refer me to another clinician, Psychiatrist or mental health professional at that time. I also understand that I retain the right to refuse any medication prescribed by my doctor, and any lab test ordered. I understand that my treatment may be for an emotional, psychological, or relationship problem for which I may be prescribed therapy, medication, counseling, testing, or any of the above in combination. I hereby consent to follow treatment suggestions, or to directly inform my therapist of my objections to doing so if any.

By signing this consent I am agreeing to report any suicidal or homicidal feelings to my clinician. I hereby agree to call my clinician or his backup doctor should my suicidal or homicidal feelings intensify to the point that I feel unable to prevent myself from acting on them. I further understand that my doctor may suggest I enter a hospital at that time for my own protection or for the protection of others. In such a case I understand I will be asked by my doctor to voluntarily agree to hospitalization. Should I refuse admission as recommended at that time for any reason, I understand that my doctor may contact the public mental health authority and/or the local police department to institute an involuntary hospitalization.

I understand that my clinician desires to permit the maximum amount of freedom possible in the treatment process. Only those circumstances in which I present a danger to myself, a danger to others, or on the basis of a psychiatric illness if I am unable to provide for my own food, shelter or clothing might involuntary treatment occur. Should I choose to act on self-destructive feelings without first reporting them as agreed herein, or without allowing myself to be hospitalized, I understand that I have violated this consent and that my doctor may choose to withdraw his services or refer me to another psychiatrist.

I understand and acknowledge that I am responsible for all charges incurred by me (or any person that I am responsible for) due to services rendered. I understand that I will be given a complete accounting of all charges incurred and billed, and hereby agree to pay said charges promptly and completely after receiving my bill unless a special written payment agreement is offered by my therapist. I also hereby agree to pay any charges incurred as a result of services rendered by my doctor's on-call physician to that doctor upon being billed by him or her.

I understand that even though my clinician has agreed to bill my insurance company for my *out-patient* charges, it remains my responsibility to make sure the bill is paid within a reasonable length of time. If my insurance benefits are paid directly to me instead of to my clinician, upon receipt of said payments I hereby agree to properly endorse the checks and send them to the clinician's office. If for any reason any portion of my bill is not paid by my insurance company, I further agree to make prompt arrangements for payment in full of the balance.

CLINICIAN: _____

Patient's Signature

Date

Responsible Relative's Signature

Date

Witness

Date