

Consent for Treatment Form-Angela H Annas, LCSW

Authorization: All services are subject to authorization.

Consent: You have the right to consent to or to refuse treatment. You may also choose to withdraw from treatment. If you choose to withdraw, please notify the therapist verbally or in writing. For Medicaid recipients, you have the right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/DD/SA disability.

Benefits and Risks: You have the right to understand benefits and risks: the alleged benefits (skill improvement, the minimizing of the intensity, frequency or number of symptoms, improved coping skills, increased medication compliance and others) and the risks of treatment (cost of time and money, service dependence, etc.)

Methods of therapy used will include (but are not limited to) cognitive behavioral techniques including some dialectical methods and some mindfulness activities, interpersonal therapy and psychoeducation, among others chosen for you based on your personal strengths, your symptoms and other factors. Alternative methods of treatment include therapy using alternate methods or the use of medication only.

Participation and Feedback: You are encouraged to participate fully in your treatment. This includes providing feedback to the therapist on written surveys and in verbal form.

Therapist's Standards: As a therapist I hope to find an evidence based intervention that can provide you with quick relief from your symptoms. If I determine that I do not have the specific skills required to address your needs, I will provide a referral to another therapist.

Disclaimers: Some problems are not so quickly addressed. In some situations, progress may be noted to be maintenance of current skill level. Insurance companies often dictate which methods of therapy will be used. Clients must engage as fully as possible to get the most out of therapy. There may be times, when despite the therapist's best efforts and the client's best efforts, little progress is made.

Rights and Privacy: I acknowledge that I have received a copy of the client rights and privacy agreement and the addendum. You have the right to request a copy of your treatment plan.

Reimbursement: I give permission for therapist to bill my therapy services to each insurance company providing coverage and agree to pay copayments and deductibles at each session, unless other arrangements are made.

Medical Services: I give permission for therapist to seek emergency medical care for me in the event of the need for it. I agree that I will be liable for any charges resulting from that care. I would like you to contact my emergency contact in case of emergency. Name _____ Relationship _____
Phone Number(s) _____

Absences: I agree to provide 48 hour notice before missing a scheduled appointment. I also agree to pay a \$60 charge if I am unable to notify therapist of the need to miss an appointment with 24 hours notice. (This fee is not applicable for Medicare/Medicaid clients.)

Signature of Client

Date

Printed Name