Clinical Psychology Associates

Notice of Informed Consent

Your signature below indicates that the information below has been explained to you, and you understand and agree to the following:

1. Various existing treatment alternatives have been explained to me.
2. I understand possible treatment outcomes and side effects.
3. I understand the treatment recommendations.
4. The services to be provided and the goals and duration of treatment are set forth in my Master Treatment Plan and will be reviewed regularly.
5. I have been offered a copy of the clinic's "Patient Rights" statement.
6. I have reviewed the clinic's fee schedule, insurance practices, and payment explanation.
7. I have been offered a copy of the clinic's grievance procedure.
8. I have reviewed a copy of the clinic's alternative communications policy and been given an opportunity to ask questions about it.
9. I have been given the clinic's telephone number and an explanation of how to receive emergency services when the clinic is closed.
10. I understand that I may be involuntarily discharged from the clinic for violating clinic policy, including multiple missed appointments.
11. I understand that if I am provided medication I will need to sign a separate informed consent form and explanation for each medication prescribed.
12. I understand that I may withdraw this consent in writing at any time.
13. I understand that this form will be reviewed annually and I can request a copy of the "Patient Rights," payment explanation, grievance procedure, alternative communications policy, or discharge policy at any time.

This consent for treatment will remain in effect until treatment is terminated. You have the right to withdraw your consent for treatment in writing at any time. Please talk directly with your therapist if you have any specific questions.

_____ _____

Consumer or Legal Representative **Date**

_____ _____

Therapist **Date**