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Informed Consent for Treatment

Client Name:______________________________________ DOB:______________

Practices and Rights

Healthy Synergy Psychological Services, LLC is dedicated to providing high quality therapeutic services to children, adolescents, adults, couples, and families, regardless of age, race, sex, religious affiliation, sexual orientation, or disability. Psychotherapeutic services are regulated by the Maryland State Department of Health and Mental Hygiene.

- Services provided by, Healthy Synergy Psychological Services, LLC are confidential. No information will be shared with others without your written consent. **Confidentiality is limited by state law, requiring the reporting of child or elder abuse, and/or suicidal or homicidal intentions.**
- Maryland law requires Healthy Synergy Psychological Services, LLC to keep records, and those records will be kept in accordance with all legal and ethical requirements.
- I acknowledge that I have had all my questions answered about the services I am going to receive.
- I do hereby consent to take part in treatment by the therapist named below. I understand that developing a treatment plan with this therapist 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 will be informed of all treatment recommendations and the benefits and potential harms of any and all interventions, as well as treatment alternatives.
- I understand that no promises have been made to me as to the results of treatment or any procedures provided by this therapist.
- I understand that my therapist is **not** available to me 24 hours per day and that in the event of an emergency I can contact 911 or proceed to the nearest emergency room.
- I am aware that I may stop my treatment with this therapist at any time. The only thing that I will be responsible for is paying for the services I have already received. I understand that I 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.)
- I understand that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or show up for the appointment, I will be charged $100 for that appointment (except when not allowed by insurance carrier).
- I understand that if I give incomplete or inaccurate insurance information, I may be responsible for the balance if the practice is unable to collect in full from my insurance plan(s).
- I understand that my therapist may cease my treatment due to my non-compliance with treatment recommendations that are given to safeguard risk to my well-being.

My signature below shows that I understand and agree with all of these statements.

______________________________________ ______________________
Signature of Client (Parent or guardian for a minor child) Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

______________________________________ ______________________
Signature of Therapist. Date

___ Copy accepted by client. ___ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.