Full Circle Behavioral Health, PC

CONSENT TO TREATMENT

Patient/Client Name_____

I understand that:

1. Information I provide is used to establish a diagnosis and treatment plan. I will participate in the development and implementation of a treatment plan which will address my treatment needs.
2. Professional decisions regarding treatment are at the discretion of Full Circle Behavioral Health, PC.
3. My treatment plan may include medications, psychotherapy, group and individual counseling referral follow-up, out-reach and support services.
4. I may withdraw this consent at any time which results in the termination of my treatment.
5. The result of treatment does not have a warranty or guarantee.
6. I may discuss with my therapist any concerns or dissatisfactions I have with the care I receive.
7. I give permission to be contacted by text, email and phone and a message may be left on all numbers given to the therapist and Full Circle Behavioral Health.

I realize that:

1. My treatment information is considered confidential and the staff will respect my right to privacy with the exception of the following:

   A. Patient records and other personal data will only be released with my prior written approval and after verbal explanation of the purpose and benefit of releasing such information. The exception is releasing information to accrediting, licensing and payor organizations for financial and quality care reviews or to another healthcare provider in an emergency situation or for supervisory needs by Dr. Justin Peer.
   B. Information may also be released to the proper authorities if it is necessary to keep others or myself from being harmed. This includes abuse, neglect, exploitation and endangerment.
   C. When billing BCBS all records will be reviewed and signed by Dr. Justin Peer.

I give my permission for treatment as believed necessary by the treatment staff; that includes but is not limited to: 1) psychological testing, and 2) consult with doctors for continuity of care.

I verify that I have received a copy of the HIPPA notice of privacy._____
Initial

This consent is active and valid until the case is closed.

_____ _____
Signature of patient/parent/or legal guardian Date

_____
Printed name of patient/parent or legal guardian

_____ _____
Lori Little. MA LLP
Signature of Clinician Date