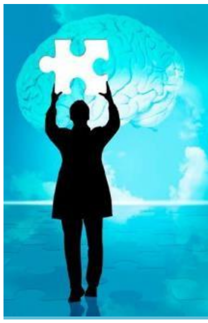

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Consent/Treatment/Assessment

- Voluntary. I am voluntarily consenting to treatment or assessment for the named patient.
- Risks and Benefits. I understand that no guarantees have been made to me about the results of the treatment or assessment; I understand the plan for treatment/assessment, and understand the potential risks
and benefits of the treatment/assessment.
-My Responsibility. I understand that it is my responsibility to inform my, or the patient's, physician if there are any significant changes in my, or the patient's physical or emotional condition.
- I understand that I have the right to terminate my treatment with my physician at any time I choose to.
-Abuse of Children and Vulnerable Adults. I understand that if a patient states or suggests that he or she is abusing or has recently abused a child or vulnerable (incompetent, mentally disabled or otherwise restricted) adult, or a child or vulnerable adult is in danger of abuse, health care professionals are required
by law to report this information to the appropriate social service and/or legal authorities.
-Duty to Warn and Protect. I understand that if a patient discloses intentions or a plan to harm another person and has the ability to carry out that plan, health care professionals are required to warn the intended victim and report this information to legal authorities. In situations where a patient clearly indicates plans to harm him/herself, that health care professional is required to notify appropriate authorities or family members.
-Laboratory Testing. I understand that if my physician orders laboratory testing for me, my laboratory will require my diagnosis for insurance billing purposes. I give my permission, in such an event, for my physician to disclose my diagnosis, either in writing, or verbally, or via facsimile, to the laboratory requesting this information.

____________________________ ________________
Patient/Responsible Party Signature Date

____
Printed Name