THE PSYCHOLOGY CLINIC, Inc.

CONSENT TO RECEIVE TREATMENT

Clients of The Psychology Clinic, Inc. have the right:

To be provided with specific, complete and accurate information about the treatment that is being proposed, which includes:

1. The purposes and expected benefits of the proposed treatment
    - The methods of the proposed treatment
    - The possible side effects of the proposed treatment
    - The alternatives to the proposed treatment
    - The possible consequences of not receiving the proposed treatment
2. If the proposed treatment is to include medication, the possible side effects, instructions for use and precautions of the medications in writing
3. The fees you are expected to pay
4. Under what circumstance we may involuntarily discharge someone for inability to pay or for behavior not reasonably the result of mental health symptoms
5. To participate actively in the development of your treatment plan and to request a second opinion concerning the proposed treatment
6. To review the proposed plan of treatment and recommended duration of treatment regularly
7. To meet with the supervising psychologist of your therapist at any time during treatment
8. To be treated without discrimination because of previous treatment history
9. To refuse medications or other treatment, except in an emergency or if ordered by a court
10. To confidentiality of your treatment records as prescribed by federal and state laws
11. To bring damages against persons violating their rights or confidentiality
12. How to use the grievance process
13. How to access after-hours emergency services
14. To be given a copy of this document
15. To withdraw this consent at any time, in writing

Your signature on this form indicates that you understand your rights and you have access to all your questions about services at The Psychology Clinic, Inc. satisfactorily answered. Your signature also indicates that you have been given access to written copies of your Consent to Receive Treatment form and have been provided written information concerning, and am fully aware of, the clinic's Policies and Practices to Protect the Privacy of Health Information and the clinic's Client Bill of Rights and Grievance Policy and Procedures.

This consent is effective for twelve (12 months) or until treatment is terminated.

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Client Name (Please Print)

_____ _____

Client/Legal Representative signature **Date**

_____ _____

Provider Representative signature **Date**