Informed Consent for Treatment

Find Balance, Build Your Strengths, and Achieve Mental Well-Being.

Name:______________________________ DOB:______________________________

This form is an agreement between you and Weston Psychiatric. The use of the word "I", "my", or "me" below may refer to you, your child, or another person for whom you serve as a legal guardian.

I voluntarily agree to receive mental health and/or substance use assessment, care, treatment, or other services and authorize Weston Psychiatric to provide such services as are considered necessary and advisable. Treatment relationships come with rights and responsibilities as described below.

I understand and agree that:

- I will participate in the planning of my treatment services, and can refuse to participate in particular interventions or techniques as outlined by my provider. I have the right to ask questions and seek clarification.
- I can stop treatment at any time.
- I have a right to confidentiality within limits provided for by law.
- I have a right to access my treatment records, or request that my provider share them with a third party such as my primary care doctor.
- My provider has the right to discontinue treatment and refer me to another agency.
- Treatment involves sharing sensitive, personal, and private information that at times may be distressing. During the course of treatment, there may be periods of increased negative emotions. The outcome of treatment is often positive; however, the level of satisfaction for any individual is not predictable.
- My provider may be receiving supervision. If this is the case, my provider will discuss this with me and I will be notified of the name and contact information of the supervisor.
- My provider is engaging in a treatment relationship with the me, and may not participate in legal proceedings on behalf of myself or my family members. I understand and agree that if I want a provider who participates in legal processes and decisions, that I will ask for a referral to an outside agency to provide such services. I further understand and agree that if my provider is subpoenaed at the request of someone representing me in legal services that I must pay a fee to my provider of not less than $2,000.00 in advance of the court date to cover the cost of record review, lost business, and the costs of consultation for the provider's legal representative.
- My provider reserves the right to decline to write letters, provide work excuses, or fill out disability or workman's compensation forms if they deem it outside of their competency or otherwise not in the interest of treatment goals.
- My provider does not consent to any recording (audio, visual, or other) of services provided without their written consent. I agree that I will not record any component of the services I receive without the individual consent of my provider.

I, the undersigned, acknowledge that I have both read and agree to all the terms and information contained herein. I am aware that I have the opportunity to ask questions and seek clarification of anything that is unclear to me.

______________________________	______________________________
Signature (First & Last Name)	Printed (First & Last Name)
______________________________	______________________________
Name (if different than patient)	Date (mm/dd/yyyy)