Penn Psychiatric Center/Collegeville Psychological Center

3774 Ridge Pike
Collegeville, PA 19426
610-489-3333 / FAX: 610-489-9390

601 Gay Street, Suite 6
Phoenixville, PA 19460
610-917-2200 / FAX: 610-917-2360

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INFORMED CONSENT FOR TREATMENT

____

Name: (Last Name) (First Name) (MI)

I, ____, the undersigned, hereby attest that I have voluntarily given my consent for treatment or the treatment of the minor or person under my legal guardianship mentioned above, at **Penn Psychiatric Center, Inc**., hereby referred to as the **Center**. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or nurse in collaboration with his/her supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The **Center** encourages that this decision be discussed with the treating clinician(s). This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights and HIPAA pamphlets and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the HIPAA Privacy Officer.

Non-Voluntary Discharge from Treatment: A client may be terminated from the **Center** non-voluntarily, if: A) the client exhibits physical violence, threatening behaviors, verbal abuse or aggression, carries weapons, or engages in illegal acts at the Center, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the **Center** Director or request to re-apply for services at a later date. C) the client exhibits behavior that would compromise the safety or confidentiality of clients or the **Center** staff.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the **Center** is protected by Federal and/or State law and regulations. As a rule, the **Center** may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as a mental health consumer or an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, insurance payees requests or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. It is the Center's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients under the age of 14 have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

Attendance Policy: PPC is dedicated to providing the most effective treatment to all those who seek services. In order to do this it is important for clients to attend all scheduled appointments. Additionally, individuals who demonstrate a pattern of cancelled or missed appointments may no longer be able to receive treatment with the Center.

Payment: I hereby authorize any insurance benefits to be paid directly to the **Center** and I understand that I am financially responsible for non-covered services. I also authorize the **Center** to release any information required in the processing of this claim.

I consent to this treatment and agree to abide by the above stated policies and agreements with **Penn Psychiatric Center, Inc**.

Client/Parent/Guardian Signature: ____ Date: _____________

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Witness Signature : ____ Date: _____________