Center for Family Psychiatry

1235 Industrial Drive, Suite 4
Saline, MI 48176

Phone: 734-944-8300
FAX: 734-944-8303

Name: _____ DOB:_____

CONSENT TO TREATMENT

- ❑ I acknowledge that I am voluntarily authorizing services for myself, or my child, with _____. I have been informed of the purpose of treatment, the service(s) that may be provided, and any attendant benefits, risks, and/or consequences.

- ❑ All information shared in treatment sessions will be kept confidential. The clinic staff will not speak to anyone on your behalf without your explicit written permission. There are four exceptions to confidentiality:

  1. The clinic staff is mandated by law to report any suspicions of child abuse or neglect to the Protective Services division of the Family Independence Agency (DSS).

  2. In the event that you are seriously planning to harm a third party, the clinic staff are mandated (under the "Duty to Warn" and "Duty to Protect" laws) to contact the intended victim and/or agencies that will help you through the crisis.

  3. Similarly, in cases of suicidal intent, your doctor or therapist may decide in the interests of protecting you from harm against yourself to recommend hospitalization, notify family members, individuals, and/or agencies that will help you through the crisis.

  4. If you experience a medical emergency while in my office and are unable to communicate, the clinic staff are obligated to give your name and any pertinent medical information to the emergency medical technicians.

- ❑ I understand that I am to provide at least 24 hours notice in the event that I need to cancel or reschedule my appointment. If I cancel my appointment in less than 24 hours, I will be responsible for a $40 late cancel fee. I understand if I no show my scheduled session, I will be responsible for a $60 no show fee. Exceptions to this policy include cases of emergency or prohibitive weather conditions.

- ❑ If I am late to my appointment, I understand that the session will still end at the previously scheduled time, or may require that I reschedule my appointment, per the provider's discretion.

- ❑ If I initiate terminating my treatment, I will give at least 2 weeks notice to the doctor or therapist in order to discuss an aftercare plan and/or referral options, as needed.

- ❑ I understand I may be discharged from the practice if I have 3 no show/late cancels in 3 months, at the discretion of my Physician/Clinician. **_____ (initial here)**

I have been provided the "Notice of Privacy Practices" and can request my own copy. I have read this consent form and I agree to the conditions specified above.

Patient/Client Signature or Legal Guardian for minors	Date
Psychiatrist/Therapist Signature	Date