



CONSENT TO TREATMENT

Please read, complete, and sign this form before your first appointment.

Authorization for Treatment

I voluntarily request that The Family Center and its designated clinicians provide evaluation, psychotherapy, psychiatric medication management, or other appropriate behavioral health services to me or my minor child.

I understand that treatment recommendations, benefits, risks, and alternatives will be discussed with me as appropriate. I understand that I may ask questions about my treatment at any time.

Confidentiality

I understand that my treatment records and communications are confidential and will be handled in accordance with applicable Maryland law. Information will not be disclosed without my written authorization, except when disclosure is permitted or required by law, including circumstances involving a serious risk of harm to myself or another person, suspected abuse or neglect when reporting is required, or a valid court order. I understand that the limits of confidentiality may be explained in greater detail by my clinician.

Communication Preferences

Please indicate the methods you authorize The Family Center to use for routine communication regarding your care:

☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email

I understand that I am responsible for keeping my contact information current and for reviewing the practice's Policies and Procedures, which I will sign separately.

Acknowledgment and Consent

By signing below, I confirm that I have read and understand this Consent to Treatment. I voluntarily consent to the evaluation and treatment of my presenting concerns and understand that I may ask questions or withdraw my consent at any time.

Client / Patient Name: _____

Date of Birth: _____

Signature of Client or Parent/Guardian: _____

Printed Name of Parent/Guardian: _____

Relationship to Minor Patient (if applicable): _____

Date: _____

Emergency Contact

Emergency Contact Name: _____

Emergency Contact Telephone: _____