PATRICK BALDWIN, LCSW

PATIENTS/CLIENTS INFORMED CONSENT

I have chosen to receive treatment services under a benefit plan covered by my insurance, which may or may not be managed by another company or one of the company's affiliates. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state laws and HIPPA regulations regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that I may be contacted by my insurance company or one of its affiliates (1) to ensure continuity and quality of my treatment and/or (2) after the completion of treatment to assess the outcome of treatment.

I have read and had explained to me the basic rights, which include:

1. The right to be informed of the steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to these services.
3. The right to humane care and protection from harm, abuses, or neglect
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that my therapist may disclose any and all records pertaining to my treatment to my insurance company's representative if disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, or utilization review purposes. I understand that I can revoke my consent at any time, and if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above:

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Signature of Witness Date