Integrated Psychiatric & Medical Care
Diligence Care

CONSENT FOR TREATMENT

I authorize and request that my provider at Diligence Care Plus carry out psychological examinations, treatment, and/or diagnostic procedures which now or during my care as a patient are advisable.
I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

TERMINATION
If at any point your provider determines that he or she is not able to provide the exact services you require, he or she will discuss this with you and, if appropriate, will terminate treatment. In such case, you will receive a number of referrals, which may be of help to you. If you request and authorize in writing, your provider will talk to the provider of your choice to help with the transition. If at any time you want another professional's opinion or want to consult with another provider, your provider will assist you in finding someone qualified, and if he or she has your written consent, will provide him or her with the essential information. You have the right to terminate services at any time.
If you choose to do so, your provider will provide you with names of other professionals whose services you might prefer.

DUAL RELATIONSHIP
The provider-patient relationship never involves sexual or business relationships nor does it involve any other dual relationship that impairs your provider's objectivity, clinical judgment, therapeutic effectiveness or can be explosive in nature.

RELEASE OF INFORMATION
I authorize the release of information for claims, certification/case management, and other purposes related to the benefit of my health plan.

NOTICE OF PRIVACY
A notice of privacy practices in compliance with the health insurance portability and accountability act (HIPAA), describing how information about you may be used and disclosed and how you can get access to this information is provided to you. please review it carefully. I have received the notice of privacy practices. I have been provided an opportunity to review it.

I understand and agree to all the above information.

Patient/Parent/Guardian Name: ……..

SIGNATURE Patient (or Parent/Guardian): ……