CONSENT TO TREATMENT

I, _____, consent and agree voluntarily
(Please print client name)
to receive services from **Jewish Family Service of the Desert (JFS).** These services may include, but are not limited to, diagnostic assessments, individual, group, and/ or family therapy and consultations and referrals to other behavioral health professionals.

Please initial each item below to acknowledge you have read and understood the terms.

_____I understand that by consenting to treatment, personal health information may be exchanged in a limited way for treatment, payment and healthcare operations purposes, only.

_____I understand that I have the right to terminate treatment at any time. I also understand that I have the right to refuse to implement any recommendations, psychological interventions, or any treatment procedures.

_____I understand that I am expected to benefit from treatment, but there is no implied or expressed guarantee that I will.

_____I understand that JFS is an outpatient clinic and uses an after-hours answering service when the office is closed at night, holidays and weekends. I understand that in the event of a psychiatric emergency, I will be directed by the answering service to call 911.

Client Name_____ Signature_____ Date_____