Arkansas Psychiatric Clinic

Consent for Treatment

Informed Consent: We ask that patients sign the following general consent to treatment. The patient may at any time decline specific recommendations.

I give my consent for services with_____________________________and associated professional staff to include evaluation, psychotherapy, testing (if indicated) and involvement in the treatment planning process.

As a courtesy to our patients Arkansas Psychiatric Clinic will call to confirm appointments, do we have your permission to leave a message about your appointment?

You may call my home or office and leave a message

Call my home only

Do not leave a message

You have permission to send/fax work/school excuse upon my request.
(Document will have Arkansas Psychiatric Clinic header)

MINORS

We require permission from the parent or guardian to treat any child under the age of 18 years old. We will not be able to see any children without a signature. Children under 18 years of age must be accompanied to his or her appointment by their parent or legal guardian. **Please never leave your children unattended at any time.**

Signed____Date____________________

Witness____Date____________________

Authorization for Use or Disclosure of Protected Health Information

I hereby give permission to Arkansas Psychiatric Clinic to release ________ Billing Information, _______ Medical Information to the following:

Name	Relationship to Patient
Name	Relationship to Patient
Patient or Guardian Signature	Date

APC# (Clinical Use): _____________