SPECTRUM BEHAVIORAL HEALTH

1509 Ritchie Highway
Suite F
Arnold, MD 21012
Office: (410) 757-2077

49 Old Solomon's Island Road
Suite 303
Annapolis, MD 21401
Office: (410) 573-1944

CONSENT TO TREATMENT

I, _____, voluntarily request treatment from Spectrum
(patient or guardian)

Behavioral Health for _____. I have completed the Patient
(Patient Name)

Registration forms and reviewed the Privacy and Payment Policies. I fully understand these documents and agree to their terms.

I understand that it is important to discuss with my clinician the nature of treatment, which may include diagnostic formulation, methods, estimated frequency and goals. It is also important to discuss any limits there may be to confidentiality. I understand that information concerning this case can only be discussed with a third party with my consent unless mandated by law, such as in the risk for physical injury or reporting of abuse.

I understand that there may be occasions where it would be helpful or necessary for my treatment provider to speak with other health care professionals within Spectrum Behavioral Health about my case and I authorize such communications unless I specifically request that information not be shared. If information is to be shared with other professionals outside of Spectrum Behavioral Health I will need to authorize such communications with a written Release of Information.

I further understand that behavioral health treatment offers no guarantee with regard to improvement of my condition. I am aware that I may withdraw from treatment at any time but if I decide to terminate treatment, I understand that it is important to discuss that with my provider first.

I certify that I have read the above Consent to Treatment and that I fully understand and agree with its terms.

_____
Signature of Patient or Legally Responsible Individual

_____ _____
Printed Name of Patient or Legally Responsible Individual Date