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INFORMED CONSENT

Your Rights and Responsibilities:

1. The information you provide during your evaluation or treatment is confidential with the following exceptions:
   A. Serious threat of harm to yourself or others.
   B. Child abuse must be reported.
   C. Those to whom you have authorized or to whom you later authorize me in writing.

1. In Worker's Compensation cases your reports and treatment notes will be sent to your Worker's Compensation carrier and doctor.

2. You have the right to get a second opinion or terminate treatment or evaluation at any time.

3. If I have difficulty collecting fees from your insurance company or carrier, your signature below indicates your approval for me to (a) release requested documentation or other information necessary to process this claim, (b) File a complaint with the Colorado Division of Insurance in your name.

4. I do not provide 24-hour emergency service. In case of emergency you are advised to contact your county mental health office, call 911 or go to the nearest emergency department for assistance.

5. You are entitled to receive information from your provider about fees, methods of therapy or evaluation, methods and techniques used and duration of treatment or evaluation (if it can be determined).

6. Sexual contact between therapist and client is not part of any recognized therapy. Sexual intimacy between patient and therapist is illegal. This should be reported to the state grievance board: Colorado State Grievance Board, 1560 Broadway, Suite 1370, Denver, Colorado 80302, 393-894-7766.

By signing below I certify that I have been informed of my therapist's or evaluator's credentials and license. I further certify that I have read this agreement or that it has been satisfactorily explained to me. I understand my rights.

Patient's Name Patient's Signature

Date

Guardian Name (Relation to patient) Guardian Signature

Date

Therapist/Examiner Signature Date