Carrousel Therapy Center

3201 Budinger Ave
Saint Cloud, Florida 34769

COMBINED CONSENT

Service Date:	

I. ☐
I have received the Consumer Handbook. I was given time to ask questions and I understand the answers that were given to me. (initial here)

The Consumer Handbook has information on the following subjects:

- **Consumer Rights and Responsibilities**
- **Rights and Responsibilities**
- **Confidentiality and Release of or Request For Information Policies**
- **Notice of Privacy Practices**
- **Grievance Procedure**

II. (initial here) ☐
I have been provided with a list of Recommendations for Emergencies After Hours

III. (initial here) ☐
Consent to Treatment

I understand that all information, including client assessment, treatment notes, etc. are treated with strict confidentiality and that no information, either verbal or written, will be shared without the written consent of legal guardian (if client is under the age of 18). I understand that individuals responsible for care through Company will need to have access to confidential information for the purpose of assessment and treatment coordination. By law, rules of confidentiality do not hold under the following conditions:

1. If abuse or neglect of a minor, disabled or elderly person is reported or suspected, the provider is legally required to report concern to Department of Children and Families

2. If, during services, the professional receives information that someone's life is in danger, that professional has a legal duty to warn the threatened individual.

3. If Company or staff testimony is subpoenaed by Court Order, we are required to produce records or appear in court to answer questions about the client.

4. I consent to treatment taking place at the following location(s):

◯ **Home** ◯ **School** ◯ **Office** ◯ **Tele-Medicine**

IV. Coordination of Care (Please select one)

◯ **I consent to coordination of care with Primary Care Physician when clinically appropriate. I also authorize the staff from Company, Inc. to release monthly updates regarding medication changes to the Primary Care Physician for the purpose of continuity in care if applicable. I consent to coordination of care, which may include sharing information verbally or in writing**

through psychotherapy notes related to my/my child's treatment with all Company Staff and Contract Staff when clinically appropriate. (initial here) ☐

◯ I do not give consent for CBHS to coordinate care with my PCP, checking this box I am declining consent (initial here) ☐

V.
Financial Responsibility (initial here) ☐

I understand that I must disclose all insurance coverage. If failure to disclose results in a denied claim, I will be financially responsible. Information on this page has been explained to me. I understand that I may revoke this consent at anytime except for action that has already been taken. A copy of this form shall be as valid as the original for a period of one year from date of signing.

CLIENT SIGNATURE

Printed Name	Signature	Date

PARENT/GUARDIAN SIGNATURE

Printed Name	Signature	Date

THERAPIST (WITNESS) SIGNATURE

Printed Name	Signature	Credentials	Date