

COMBINE CONSENT

COMBINE CONSENT TO TREATMENT

Section 1 - Consumer Handbook

I have received the Consumer Handbook. I was given time to ask questions and I understand the answers that were given to me.

YES

The consumer handbook has information on the following subjects:

1. Consumer rights and responsibilities
2. Confidentiality and release of request for information policies
3. Notice of private practices
4. Grievance procedures

Section 2 - Emergencies After Hours

I have been provided with a list of recommendations for emergencies after hours.

YES

Section 3 - Consent to Treatment

I understand that all information, including Clients Assessment, Treatment Notes, etc. are treated with strict confidence and no information, either verbal or written, will be shared without the written consent of Legal Guardian (if Client is under age of 18). I understand that individuals responsible for care through Carrousel Therapy Center Corporation will need to have access to confidential information for the purpose of Assessment and Treatment coordination. By Law, rules of confidentiality do not hold information 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 professionals receive information that someones life is in danger, the professional has the 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.

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

HOME SCHOOL OFFICE TELEHEALTH

Section 4 - Coordination of Care

I consent to coordination of care with primary care physician wen clinically appropriate. I also authorize the staff from Carrousel Therapy Center Corporation to release monthly updates regarding medication changes to primary care physician for the purpose of continuity in care if applicable. I consent to coordination of care, witch may include sharing information verbally or in writing to psychotherapy notes related to me or my children's treatment with all Carrousel Therapy Center Corporation staff.

I do not give consent for Carrousel Therapy Center Corporation to coordinate care with my PCP.

CARROUSEL THERAPY CENTER CORPORATION

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Section 5 - Financial Responsibility

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

YES

Section 6 - Signatures

Client Signature

Client/Parent/Guardian Full Name	_____	
	Client Signature	Date

Therapist Full Name	_____	
	Therapist Signature	Date