Consent for Treatment
Innersight LLC

Freedom of Choice

I have chosen to receive mental health services for myself and/or my child from Innersight LLC. My decision is voluntary and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

Nature of Mental Health Services

I understand that during the course of treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

Compliance with treatment plan

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

Insurance

I agree that all services will billed directly to my insurance plan. I am responsible for the cost any copays or unmet deductibles and will be charged by Innersight. If my insurance changes I will notify Innersight LLC. Loss of insurance may result in services being terminated.

Supervision

I understand there are certain circumstances which may require Innersight LLC provider(s) to receive supervision. These circumstances include, but are not limited to the following:

1. State licensure regulations may require my therapist or service provider to receive ongoing supervision
2. Accreditation organizations, as well as insurance companies, may require that my treatment plan be reviewed
3. The standards of care which guide most mental health professional recommend that supervision and/or consultation be obtained in high risk situations such as threats and/or acts of harm to self or others
4. Other special circumstances, such as preparation to testify in court

Client Rights

- The right to be treated with dignity and respect by all staff
- The right to be involved in the planning and/or revision of my treatment plan
- The right to know about my treatment progress or lack thereof
- The right to reject the use of any therapeutic technique, and to ask questions at any time about the methods used
- The right to be spoken to in a language that is fully understood
- The right to a clean and safe environment
- The right to refuse to be videotaped, audio recorded, or photographed
- The right to end treatment at any time unless court ordered
- The right to file a complaint or grievance about the agency or staff
- The right to confidentiality of clinical records and personal information according to federal and state laws
- The right to choose the provider of therapy

Emergencies

I understand I may reach my therapist via provided cell phone number and will return my call within one business day unless otherwise specified on the voicemail. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life threatening emergency situation, I may call 911, report to the nearest emergency room or call the Westmoreland County Crisis Hotline at 1-800-836-6010.

I have read, discussed and understood all of the above.

Client Name___________________________________ DOB:___________________

____ Date:___________________
Signature of client if 14 and over or parent/guardian if under 14