



PATHWAY CLINIC



## Consent for Treatment

I am voluntarily seeking services at Pathway Clinic, SC / The REDI Clinic, a division of Pathway Clinic, SC for myself, \_\_\_\_\_ or my minor child, \_\_\_\_\_.

I hereby seek and consent to take part in treatment at Pathway Clinic, SC / The REDI Clinic, a division of Pathway Clinic, SC. I understand that developing a treatment plan with my therapist or member of my treatment team and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by my therapist and/or treatment team. A copy of "DHSS Patient Rights" has been made available to me. I agree to consultation between Pathway Clinic/The REDI Clinic staff for the purposes of aiding in diagnosis and treatment for my minor or myself. I agree to keep my scheduled appointments, or cancel at least 24 hours in advance of an appointment. If I do not cancel and do not show up, I will be charged for the missed session. It is preferable that termination of therapy is an agreement between the therapist/treatment team and myself, but I understand that I have the right to discontinue treatment at any time. I understand that I may obtain emergency services during periods outside of operating hours. If I choose to stop treatment, I agree to be responsible for any fees incurred during treatment, including missed appointment fees.

I understand that treatment information shall be considered confidential, but may be released upon my written permission. Exceptions to this confidentiality include the therapist's responsibility to protect the rights and safety of the client and others. This pertains to instances of child abuse, threats of suicide or harm to others. I also understand that if I choose to utilize insurance/third party payer for payment of treatment, information may be given relating to diagnosis, type, cost and dates of services I receive. This information may be transmitted electronically.

I agree to charges for my treatment as listed on the fee schedule. I authorize payment directly to Pathway Clinic, SC/The REDI Clinic by insurance, for services rendered. I agree to pay my insurance co-pay before each scheduled appointment. **I guarantee payment of any charges incurred for services rendered, which are not covered by this assignment or by insurance benefits.** I agree that if I fail to pay for services, information regarding these services will be released to collections and I will then also be responsible for collection costs.

**Print Client Name:** \_\_\_\_\_

**Client/Parent Signature:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_