Solutions
Psychiatric Associates
A MEDICAL CORPORATION

16450 Los Gatos Blvd. #112
Los Gatos, CA 95032
Main# 408.402.0450
Fax # 408.402.0950

Consent to Treatment

Welcome to Solutions Psychiatric Associates, A Medical Corporation. We offer counseling, assessment and psychiatric services for children, adolescents, families, and adults. These services are provided through individual, family, couples and group treatment formats. We want you to be sure that you understand the nature of the services that you are receiving and need you to read the information below and to sign and date this form.

I, _____, hereby request for myself, or my minor child, _____, to receive psychiatric and/or psychological care and treatment voluntarily from Solutions Psychiatric Associates, A Medical Corporation. I understand that such care and treatment may consist of an evaluation process, counseling, and case management.

Solution Psychiatric Associates is hereby authorized to provide the treatment/services described above if this request is accepted. Such consent, however, does not waive my civil rights; I reserve the right to decline treatment against the advice of my clinician(s) at any time. I also have the right to request a change of clinician(s) without being subjected to discrimination or any penalty.

I further understand that my records are considered pursuant to W & I 5328 and will not be released to outside individuals or agencies without my expressed written consent. However, I realize that certain information may be released without my authorization under specific circumstances including, but not limited to, the following:

1. Suspected child physical and/or emotional abuse and dependent adult or elder abuse must be reported to the authorities immediately. This may include sexual contact between an adult and a child.
2. If a client implies a serious threat of violence or danger to a person or his/her property, the clinician is bound by duty to forewarn that person and to notify the authorities (police).
3. A therapist may provide reasonable protective care to a suicidal client, under certain circumstances.
4. Counseling records may be subpoenaed by court of law, under certain specific circumstances.
5. A release of information is signed by the client to authorize the counselor to obtain and exchange information with outside individuals/agencies relevant to treatment.
6. Within our organization, we work as a team. Thus, one professional staff member may periodically consult with other qualified professional staff members to ensure that we are delivering the highest quality services to our clients. All of our staff is bound by the same requirement for confidentiality.

I also understand that anonymous information, designed so that my family and I cannot be identified, may be utilized for training purposes.

I have been informed that my clinician(s) is/are:

☐ a licensed clinician
☐ a clinician working toward licensure under the supervision of the following:
licensed psychiatrist:_____ Lic.# _____
☐ a licensed psychiatrist _____ Lic# _____

☐ I am authorized to consent to treatment. I have read the above and I agree to accept treatment for myself/my child, and I further agree to all conditions set forth herein.

_____ _____
Client/Parent or Guardian Signature Date

_____ _____
Client/Parent of Guardian Signature Date

_____ _____
Witness/Clinician Date