MONARCH BEHAVIORAL HEALTH ASSOCIATES

CONSENT TO TREATMENT

In entering a therapeutic relationship with ___________________________. I consent to the use of confidential telehealth psychotherapy sessions **if requested or required**. If used, these sessions will occur via secure communication. If you do not consent, please check here_______ and sign our **Telemental Health Informed Consent form.**

I understand that I have the following rights and obligations to:

1. Non-discriminatory psychotherapeutic treatment regardless of my race, religion, social economic status, sexual orientation, physical restrictions;

2. Review my psychotherapist's credentials and experience;

3. Be fully informed about costs, appointment times and confidentiality.

3. Be fully informed about the goals of my therapy and the methods used to reach those goals

4. Refuse treatment or testing at any time, unless there are legal reasons that prevent such action

5. Obtain summary of my treatment record and have addenda made to the contents of my clinical records authorized by my clinician

In addition to the above rights, I as a patient understand that/ am obligated to:

1. Keep all appointments on time. If the need to cancel a session arises, 24 hours' notice must be given to the therapist. You will be billed in full personally for any sessions that have not been canceled without 24 hours at the rate which your health insurance reimburses per session;

2. Payment or co-payment must be made at the time of the therapy session.

3. Any telehealth therapy appointments will be charged at the same rate as individual therapy.

The therapist must maintain full confidentiality about therapy sessions. **Other than my direct Supervisor**, no information will be released to anyone without the patient's written consent. The consent form is time limited and specific in terms of what can be released and to whom. Confidentiality can only be breached, according to state law, when child abuse is reported, or a person's life or safety is threatened. Under these conditions, the therapist is mandated to report the child abuse and/or intent with plans to commit suicide or homicide to the appropriate authorities.

I fully understand the above contract for therapy and am willing to abide by its contents.

Patient:____Date:____________________

Therapist:____Date:____________________

At MBHA, we strongly believe in open and honest communication between those in marital relationships. For this reason, we will not keep information regarding infidelity as privileged in the continuation of therapy. If we discover that infidelity has or is occurring, we will discontinue the therapeutic relationship if you choose not to disclose this to your partner. By signing below, you consent to the understanding of our policy

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