I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  have received a copy the Consumer Handbook that has information on the following subjects: Consumer Rights and Responsibilities, Company’s Policies and Procedures, Confidentiality and Release of Information Policies, Notice of Privacy Practices, Grievance Procedure & Recommendations for Emergencies after Hours.I Consent to Treatment & I understand that all information, including client assessment, progress notes, etc. are treated with strict confidentiality and that no information, either verbal or written, will be shared without the written consent of legal guardian (if client is under the age of 18). I understand that individuals responsible for care through OPCS will need to have access to confidential information for the purpose of assessment and treatment coordination. **By law, rules of confidentiality do not hold under the following conditions:**

* 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
* If, during services, the professional receives information that someone’s life is in danger, that professional has a legal duty to warn the threatened individual.
* If OPCS or staff testimony is subpoenaed by Court Order, we are required to produce records or appear in court to answer questions about the client.

Please **initial box A and B** if you consent to the above and consent to treatment; **initial box C** if you give consent for OPCS to coordinate care with my PCP and sign below.

[ ]  A. I consent to treatment at home, school, OPCS office & Telemedicine (visual through phone/Computer)

[ ]  B. I consent to coordination of care with Primary Care Physician when clinically appropriate. I also authorize the staff from OPCS, Inc. to release monthly updates regarding medication changes to the Primary Care Physician for the purpose of continuity in care if applicable. I consent to coordination of care, which may include sharing information verbally or in writing through psychotherapy notes related to my/my child’s treatment with all OPCS Staff and Contract Staff when clinically appropriate.

[ ]  C. I do not give consent for OPCS to coordinate care with my PCP, checking this box I am declining consent

I understand that I must disclose all insurance coverage. If I failure to disclose results services will be terminated.

I acknowledge that the 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 be as valid as the original for a period of one year from date of signing.

|  |  |
| --- | --- |
|  |  |
| **Client’s signature:**  |  | **Date:** |  |
| **Parent/Guardian Signature**: |  | **Date:** |  |
| **Witness Signature:** |  | **Date:** |  |