SUMMERVILLE PSYCHIATRIC ASSOCIATES

INFORMED CONSENT FOR TREATMENT

Confidentiality

I acknowledge the session content and all relevant materials to my treatment will be held confidential unless I request in writing to have all or portions of such content released to a specifically named person(s). Limitations of such patient-held privilege of confidentiality exist and are itemized below:

1. If a patient threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a patient threatens grave bodily harm or death to another person.
3. If the healthcare provider has a reasonable suspicion that a patient or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
   -Suspected neglect of the parties named in items #3 and #4.
   -If a court of law issues a legitimate subpoena for information stated on the subpoena.
   -If a patient is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Consent to Examination and Treatment

I consent to have Summerville Psychiatric Associates and its professional staff perform or order examinations, psychotherapy, and/or related mental health treatments.

I consent to have medications ordered when deemed necessary or advisable by the appropriate members of the professional staff and/or consultants in consultation with Summerville Psychiatric Associates.

BY SIGNING BELOW I AGREE THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Name (Print): _____

Signature: _____ Date: _____

Patient Name (if different from above): _____