Marshy Hope Family Services, LLC
Consent for Treatment

Client Name: ____

I understand that I am voluntarily consenting to treatment by Marshy Hope Family Services (MHFS).

I understand that I may discontinue treatment at any time and that no promises have been made to me as to the course of results of such treatment as has been recommended by the staff.

I understand that, in a medical or psychiatric emergency that may be life-threatening, MHFS staff may render emergency treatment for myself or clients in my custody.

I understand any financial obligations I may have to pay for clinic services.

I understand that representatives of my insurance company or other third party payers may be given necessary information about clinic services, dates of service, cost of services, and staff providers of service. I understand if such third party payments for services are not made then the clinic may so inform me and the clinic may then cease services.

I understand that I must call no later than 24 hours prior to an appointment to cancel. If I do not call to cancel or if I do not show up that I may be subject to discharge, per MHFS policy (see Client Handbook).

I have reviewed and understand the Confidentiality Statement, Patient Rights Form, Discharge Policy, and Grievance Procedures posted in the clinic waiting room and available in the Client Handbook.

__________________________________ ____________________

Client/Client Guardian Signature Date

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Relationship to Client

__________________________________ ____________________

Staff Signature Date