Consent for Outpatient Treatment

HIPPA Compliant Form

I, _____, voluntarily consent to outpatient treatment with Joel Murphy.

I am aware that my therapist believes and has explained to me that this treatment will benefit me. I understand that no guarantees have been made to me as to the results of the treatment. Also, I understand that it is my responsibility to inform my therapist of any changes in my physical or mental condition.

I am aware of the professional and educational background of my therapist. I am aware that my therapist may discuss my case in case consultation with another professional according to the profession's legal and ethical standards, for the purpose of quality improvement activities.

I am aware that there are specific situations when therapists are legally required to report, to the appropriate authorities, information I reveal which clearly indicates danger of injury to myself or others (e.g., potential suicide or homicide). A therapist is also required by law to report any knowledge of abuse or neglect of a child, or an incompetent, disabled or otherwise restricted person.

I understand that Joel Murphy complies with the Health Insurance Portability and Accountability Act (HIPPA). The Practice's Privacy Notice has been provided to me prior to my signing this authorization. I understand my rights and the duties of this office with respect to my protected health information.

I acknowledge full responsibility to payment for mental health services rendered. I understand that I may be charged the full fee rate if proper twenty-four hour notification is not given for broken/canceled appointments. I understand that I have the right to terminate my treatment with my therapist at any time I choose to do so. I authorize my therapist to acknowledge my first appointment to my referral source, if applicable.

I authorize Joel Murphy to contact me for appointment and / or brief information exchange at the following locations (check all that apply).

- ☐ Cell phone _____
- ☐ Home phone _____
- ☐ Work phone _____
- ☐ Email _____

This form has been explained to me, and I certify that I understand its contents and purpose.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date