WEST YAVAPAI GUIDANCE CLINIC

General Consent to Treat

Client/Patient Name: _____

I authorize West Yavapai Guidance Clinic, Inc. to provide evaluation and treatment services.

I agree to participate in my treatment planning process to the best of my ability and will let my provider know if situations occur that prevent me from participating in treatment.

I understand that this consent will remain valid so long as I am enrolled in services with West Yavapai Guidance Clinic or until I withdraw consent. West Yavapai Guidance Clinic may use and disclose information about me and my health for the purposes of diagnosing and treating me, for obtaining payment for my care and for conducting health care operations. There are regulations that control how West Yavapai Guidance Clinic may use this information about me and my health. West Yavapai Guidance Clinic abides by these regulations. These regulations are explained in more detail in the "Notice of Privacy Practices". I have the right to review the "Notice of Privacy Practices" prior to signing this document. I understand that by signing this consent form, I am giving permission to all members of my clinical treatment team and my health insurance plan(s), which may include AHCCCS, Health Choice Integrated Care and/or Medicare, to access my information and records.

I understand that all of the information gathered in the course of my treatment is confidential. However, confidential information may be disclosed without my consent in accordance with state and federal law.

Printed Name: _____ Date: _____

Signed: _____

Relationship to Client/Patient: _____