Theresa Rader-Wilson, Psy.D, HSPP
804 N. College Avenue Suite 103
Bloomington, IN 47404

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# Consent to Treatment

I do hereby seek and consent to take part in the treatment by Theresa Rader-Wilson, Psy.D, HSPP.
I understand that developing a treatment plan with the therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in the process.

*Client/Parent/Guardian Initials* Click here to enter text.

I understand that no promises have been made to me as the results of the treatment or any other procedures provided by this therapist.

*Client/Parent/Guardian Initials* Click here to enter text.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged the fee for the service. This can not be charged to your insurance carrier.

*Client/Parent/Guardian Initials* Click here to enter text.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services that I have already received. I understand if I stop services, I may have to deal with other problems. (For example, if my treatment has been court-ordered, I will have to answer to the court).

*Client/Parent/Guardian Initials* Click here to enter text.

I am satisfied that treatment alternatives have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment.

*Client/Parent/Guardian Initials* Click here to enter text.

I acknowledge that diagnosis depends on information, and treatment depends on diagnosis. So, if I withheld information, I assume the risks that a diagnosis might be made incorrectly.

I understand I do not have to answer questions that I feel is uncomfortable or because I am in the per presence of others. Any refusal to participate in the consultation or the methods used for consultations may negatively impact consultation/treatment. My therapist agrees to discuss alternatives. If therapist deems the lack of information hinders effective differential diagnosis or treatment delivery may lead to a discussion of a referral to another practitioner and/or termination of services.

*Client/Parent/Guardian Initials* Click here to enter text.

I understand that I ordinarily guaranteed access to my records and copies of my records by **written request**. I also understand, however, that if my practitioner, in the exercise of personal judgement, concludes that providing my records could threaten another person or myself, they may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of records released to me and that I will have to pay $1.00 per page to get a copy.

*Client/Parent/Guardian Initials* Click here to enter text.

I also understand that if practitioner receives a request for my behavioral health records, the writer will only do so if she receives a HIPPA 42 CFR Part 2 request form. My current address, phone number should be on the request form so my practitioner can call me to discuss the release of records.

*Client/Parent/Guardian Initials* Click here to enter text.

I understand that if I am psychiatric emergency, I can attempt to call Dr. Theresa Rader-Wilson at 317-460-9455. If I cannot reach her, I should contact one or the following:

*My PCP: Click here to enter text. Phone #: Click here to enter text.*

*Crisis Line Hotline @: Click here to enter text.*

*Go to my nearest hospital ER: Click here to enter text.*

I have received a copy of my practitioner's contact information (telephone#, fax #, mailing address, and email address (if applicable).

*Client/Parent/Guardian Initials* Click here to enter text.

Client Signature Click here to enter text. Date: Click here to enter text.