

Katherine Peppers DNP, CPNP, CPMHS, PLLC  
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## Informed Consent to Treatment

- ✓ I will be given a clear description from my mental health provider regarding the problems, diagnosis, personal strengths/limitation and treatment interventions proposed.
- ✓ I will be given a clear recommendation for the types of treatment recommended, such as individual counseling therapy and/or psychiatric services. Times, dates and session length will be discussed with my mental health provider.
- ✓ I voluntarily agree to undergo mental health treatment and understand that I may end or refuse treatment at any time. I understand that my mental health provider may want to discuss this with me, but that I reserve the right to stop treatment.
- ✓ I understand that my mental health provider may make diagnosis and treatment recommendations with which I do not agree (e.g. modality of treatment, duration of treatment, frequency of visits, etc.)
- ✓ I understand that confidentiality of records of information collected about me will be held or released in accordance with state and federal laws regarding confidentiality of such records and information, as is outlined in the Privacy Notice provided to me.
- ✓ I understand that my provider may disclose and all records pertaining to my treatment if necessary for claims processing, care management, coordination of treatment, quality assurance or utilization of this facility and to the extent necessary to facilitate the provision of administrative and professional services.
- ✓ I understand that state and local laws require my provider report all cases in which there exists a danger to self or others or concerns for abuse or neglect.  
I agree and consent to participate in psychiatric services offered by a provider at Katherine Peppers, DNP, PLLC.

Name of Patient: \_\_\_\_\_

Signature of Patient or Parent/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_