Katherine H. Peppers DNP, PLLC
2473 Wendell Blvd.
Wendell, North Carolina 27591
919-626-0255 - Phone
kp@katherinepeppers.com
949-437-2099 - Fax

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 of 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 these exists a danger to self or others or concerns for abuse or neglect.
  I agree and consent to participate to psychiatric services offered by a provider at Katherine Peppers, DNP, PLLC.

- ✓ I have read the Consent for Purposes of Treatment, Payment and Healthcare Options and agree with the statements. Patient or Parent Initials: _____

Name of Patient: _____

Signature of Patient or Parent/Legal Guardian:_____

Date:_____