Peachtree Family Psychiatry Clinic
1720 Peachtree Street NW, Suite 320
Atlanta, Georgia 30309

Consent for Evaluation and/or Treatment

Version for Adult

Name:_____Date of Birth:____/____/_____

Record #:

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1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Peachtree Family Psychiatry Clinic. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment

   The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Georgia Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Peachtree Family Psychiatry Clinic, and I consent to disclosure for use by Peachtree Family Psychiatry Clinic] staff for the purpose of continuity of my care. Per Georgia mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

4. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

5. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

_____ _____
Signature of client ages 14 years or older **Date**

_____ _____
Signature of witness **Date**