TIFTAREA
PSYCHIATRIC AND COUNSELING SERVICES, LLC
223 East Second Street, Suite B – Post Office Box 1613 – Tifton, Georgia 31793
(229) 339-3721 – www.TiftareaPACS.com – info@tiftareapacs.com

Informed Consent for Treatment/Rights and Responsibilities

Please read each of the following and initial indicating you knowledge and understanding

1. _____ I understand that I must make and keep all appointments and that if I do not show up or cancel within 24 hours of the appointment I will be charged $25
2. _____ I understand that my therapist is _____
3. _____ I understand that my Doctor is _____
4. _____ I have been informed of the treatment process, possible risks and benefits
5. _____ I understand my privacy rights
6. _____ I understand that each provider (therapist/doctor) may provide different types of treatment options and specialties and have made an informed decision about whom I will see.
7. _____ I agree to follow my treatment plan including any family/group sessions recommended by my therapist/doctor
8. _____ I understand treatment is an interactive process and that I must work with my therapist/doctor in order to get the most out of treatment
9. _____ I understand I have the right to be treated with respect and dignity by all staff members at all times
10. ____ I understand the grievance process
11. ____ I understand that the treatment providers may have various levels of licensure, experience and training and have been informed of my provider's credentials

_____

Client/Legal Guardian's Signature Date

_____

Staff Signature Date